MCSP
MICHIGAN
CANCER SURVEILLANCE PROGRAM

Cancer Program Manual

DCH-0916 Rev. 10/26/2022

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Michigan Department of Health and Human Services
Division for Vital Records and Health Statistics
By Authority of Act 82, P.A. 1984

MICHIGAN CANCER SURVEILLANCE PROGRAM
CANCER PROGRAM MANUAL

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Michigan Department of Health and Human Services
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CANCER PROGRAM MANUAL

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Data Services Provided to Facilities

A variety of services are available to Michigan facilities providing cancer patient information to the Michigan Cancer Surveillance Program. These services are made available to support the research and planning efforts that facility staff determine are necessary and are particularly intended to aid in hospital cancer registry management and associated activities.

The key services available include:

- Hospital Specific Data or Listings
- Ad Hoc Statistical Data
- Death Searches - Death Certificates
- Death Indexes
- Microfiche - from 1985 - 1995 (135mm)
- Data Files - from 1996 to current
- Death Notices when Reported Patients Die (includes deaths in Michigan and for many other states.)

For more information on these special services contact:

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Introduction

The Michigan Department of Health and Human Services (MDHHS) is mandated by Act 82 of 1984, effective July 1, 1984, to establish a cancer registry for the State of Michigan. This statute states “the department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.”

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient. all hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the MDHHS.

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985. This manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses.

On October 1, 2004, the Michigan Cancer Surveillance Program (MCSP) implemented the collection of benign/ borderline intracranial and Central Nervous System (CNS) tumors as a new requirement.

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Contact Registry Staff

If you need assistance, please contact the MCSP staff below:

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Electronic Submission of Data

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History of the Michigan Central Cancer Registry

The history of cancer reporting in Michigan dates back to 1947 when an administrative rule was enacted to require the reporting of cancer cases. This rule was never effectively enforced until 1978, when a governor's task force was empaneled to examine the need for cancer reporting in Michigan. The recommendations from this panel prompted the department in 1980, to initiate a pilot program. By 1984, 52 hospitals were reporting cancer cases on a voluntary basis, which resulted in approximately 6,000 cases being reported each year. As the pilot project progressed, legislation to require statewide reporting was developed. On April 17, 1984, a bill to mandate statewide reporting was signed into law.

A panel was assembled to develop and design the rules for reporting incidence of cancer to the statewide central cancer registry. In 1984, the “Task Force on Administrative Rules to Implement Act 82” began meeting. The task force consisted of professional groups throughout the state who in some way dealt with cancer patients or cancer data systems. In addition, public health officials involved in health programs concerned with cancer control, and individuals involved with epidemiological cancer research, were also assigned to the task force.

The objective of the task force was to “provide advice to the department on a set of administrative rules as required by the authorizing legislation.” This panel made recommendations on data items to be collected, methods of reporting, quality control issues, confidentiality, as well as rules for reporting facilities. These cancer reporting rules were developed and outlined in the original 1984 Cancer Reporting Manual, which was approved by the original task force. On January 1, 1985, the rules for reporting cancer cases went into effect.

MCSP began tabulating cancer incidence reports on January 1, 1985. By the end of 2016, the state central cancer registry contained 2.2 million reports with 1.7 million individual cancer cases. Currently the central registry processes approximately 59,000 new reports yearly. These cases represent approximately 165 reporting facilities, which include hospitals, physician offices and laboratories.

The Metropolitan Detroit Cancer Surveillance System (MDCSS) is the authorized entity by the Michigan Department of Health and Human Services (MDHHS) for facility collection and reporting of individually identifiable cancer case surveillance data information for Wayne, Oakland, and Macomb counties, which represents approximately 60 hospitals and laboratories in these three counties. All reportable cancer case reports from Detroit area reporting hospitals and laboratories (Wayne, Oakland, and Macomb counties) are to be reported to MDCSS, and within 180 days from the data of initial diagnosis. This grant of authority by MDHHS to MDCSS, includes the collection of all information necessary to identify and track patients and their diagnoses, treatment and subsequent primaries and survival status. In its capacity as a central cancer registry, MDCSS consolidates cancer case reports from Detroit area reporting hospitals and laboratories and submits consolidated case reports to MCSP.

Facilities are able to report cancer cases to the state central cancer registry either manually on the cancer report form or electronically through the State’s free online abstracting feature in Web Plus. Hospital registries are becoming more sophisticated in their collection and transferal methods since the state cancer registry began in 1985. As of November 2022, almost 99 percent of the cases from hospitals and regional registries are involved in an automated reporting system. Automated facilities send their data through Web Plus, which is a web-based application that collects cancer data securely over the public Internet.

State cancer data has been compiled and analyzed annually since 1985. These yearly reports are produced using the submitted data and are made available on the Michigan Department of Health and Human Services – Cancer Statistics web site. As new annual reports are prepared, updated data for

prior years is developed and released to ensure that the most complete information is made available. Processing time for a report from diagnosis to manual statistics is approximately two years.

Purpose

A statewide population-based cancer registry is the only means whereby state wide incidence data for cancers by type and by area of residence can be developed. Timely information on cancer cases is employed as a basis for cancer surveillance, as a tool for initial evaluation of cancer incidence within regions of particular interest, and as a source of baseline incidence data. The registry is of value in examining the frequency of cancer by demographic characteristics such as age, race and sex and is of significant value to researchers in epidemiological case control studies. This data is also helpful in the areas of planning health education and addressing public health concerns.

Confidentiality

Cancer incidence reports and data files on cancer cases which are received by the department are afforded confidential handling as required by Act 82 of 1984, being section 2631 of Act 368 of 1978 as amended, and by administrative rule. The release of data in identifiable form is specifically prohibited, except as outlined in Rule Four. Under the rules, release of this data or reports is permitted to the individual patient or to the patient's legal representative. Information may be provided to a researcher conducting approved research, following specific protocol based upon the nature of the research. Release is permitted to a cancer registry from another state with regard to residents of that state so long as the state agrees to restrict the use of the information to statistical tabulations. Further protection of the data is afforded by sections 2632 and 2633 of Act 368 of 1978 which designates that the reports or information thereon are inadmissible as evidence in a court and which establishes a shield from liability for furnishing the information. In addition, the privacy regulations enacted in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) has a specific exemption to permit disclosing identifiable patient data to the official public health agency of a state.

Revised Reporting Requirements

In 2011, changes to the information being reported for cancer cases was initiated. These new reporting standards are designed to ensure that the registry in Michigan conforms as closely to central incidence registries operated in other states. The new data set collected conforms to the items recommended for collection by the North American Association of Central Cancer Registries (NAACCR) and are nearly the same as the recommendations by the National Program for Cancer Registries (NPCR).

The decision to change the reporting requirements was precipitated by two important developments. The first was the release of standards for the operation of a central registry which were produced by NAACCR in 2011. Concurrent with the release of these new standards were recommendations on standard items for collection released by NPCR within the Centers for Disease Control (CDC). The information being collected in Michigan did not conform to these two new sets of standards. It was apparent that the long-term usefulness of the state central cancer registry hinged upon careful review of the new standards and the development of specific recommendations for implementation in Michigan.

The initial structure for cancer reporting used in Michigan was developed in consultation with an "ad hoc task force" with members representing key organizations of cancer care and cancer research in Michigan. This group provided counsel on a number of important matters that needed to be addressed when the registry was first established. These issues included determining who was responsible for reporting, the manner the information was to be reported, timeliness requirements, and finally the specific items to be reported. The advice of this group proved to be an important key to the success of

the statewide cancer registry. This same approach was adopted with regard to re-evaluating the basic operational principles for the Michigan registry in light of the recommendations of NAACCR and NPCR.

The standards set forth by the Commission on Cancer (CoC) were also taken under advisement. A strategy for required data sets takes place in a tiered priority which conforms to the requirements of the CoC. Those facilities approved by the CoC, are required to submit more detailed information, which includes further information on staging and treatment. Those facilities with CoC approved cancer registries are perceived to have the ability of their staff to supply the central registry with this further information.

A table has been developed to distinguish the reporting requirements for approved facilities, non-approved facilities, and laboratories. Refer to “Reporting Requirements by Data Item and Facility Type” document on MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program for complete reporting instructions.

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Act No. 82 of 1984 Establishing the Central Cancer Registry

Act No. 82
Public Acts of 1984
Approved by the Governor
April 17, 1984

Filed with the Secretary of State
April 19, 1984

STATE OF MICHIGAN
82ND LEGISLATURE
REGULAR SESSION OF 1984

Introduced by Reps. Spaniola, Hertel, Barns, Dutko, Porreca, Sitz, Maynard and DeMars

ENROLLED HOUSE BILL No. 4090

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties for governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide the certain immunity from liability; to provide for penalties and remedies; and to repeal certain acts and parts of acts," as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 2619.

The People of the State of Michigan enact:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 2619 to read as follows:

Sec. 2619. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.
(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subsection (4), or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subsection (4) to ensure that accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subsection (4) may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.
(3) The department shall maintain comprehensive records of all reports submitted pursuant to this section. These report shall be subject to the same requirements of confidentiality as provided in section 2631 for data or records concerning medical research projects.
(4) The director shall promulgate rules which provide for all of the following:
(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subsection (2).
(b) The quality and manner in which the cases and other information described in subsection (1) are reported to the department.

(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this section are released by the department.
(5) This section does not compel an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required under this section.
(7) Within 2 years after the effective date of this section, the department shall begin evaluating the reports collected pursuant to subsection (2). The department shall publish and make available to the public reports summarizing the information collected. The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this section. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.
(8) Reporting pursuant to subsection (2) shall begin the next calendar year after the effective date of this section.
(9) This section shall take effect July 1, 1984.

This act is ordered to take immediate effect.

William A. Ryan

Clerk of the House of Representatives

William C. Kandler

Secretary of the Senate

Approved

Governor

Administrative Rules on Cancer Reporting

Department of Health and Human Services
Office of the State Registrar

Filed with the Secretary of State on April 16, 1985. These rules take effect 15 days after filing with the Secretary of State.

(By authority conferred on the department of public health by section 2619 of Act No. 368 of the Public Acts of 1978, as amended, being 333.2619 of the Michigan Compiled Laws.)

R 325.9050, R 325.9051, and R 325.9052 are amended; and R 325.9057 is rescinded (Eff. May 27, 2016).

R 325.9050 Registry

Rule 9050. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state. The registry shall include information concerning these cases as the department considers necessary and appropriate to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.
(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subrule (4) of this rule, or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subrule (4) of this rule by a reporting entity as defined in R 325.9051 to ensure the accuracy and completeness of the reported information. A reporting entity required to report a diagnosis pursuant to subrule (4) of this rule may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.
(3) The department shall maintain comprehensive records of all reports submitted pursuant to this rule. These reports shall be subject to the same requirements of confidentiality as provided in section 2631 of the public health code, 1978 PA 368, MCL 333.2619 for data or records concerning medical research projects.
(4) The director shall provide for all of the following:
(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subrule (2) of this rule.
(b) The quality and manner in which the cases and other information described in subrule (1) of this rule are reported to the department.
(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this rule are released by the department.
(5) This rule does not require an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required by this rule.
(7) Within 2 years after the effective date of these rules, the department shall begin evaluating the reports collected pursuant to subrule (2) of this rule. The department shall publish and make available to the public reports summarizing the information collected.
(8) Reporting pursuant to subrule (2) of this rule shall begin the next calendar year after the effective date of this rule.

History: 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9051 Definitions

Rule 9051. As used in these rules:
(a) "Primary brain-related tumor" means a primary tumor, whether malignant or benign, of the brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any part of the central nervous system or of the pituitary gland, pineal gland, or craniopharyngeal gland.
(b)"Cancer" means all diagnoses with a behavior code of 2 (carcinoma in situ) or 3 (malignant primary site) which is listed in publication found in department policy and made available to the public including carcinomas of skin of the vagina, prepuce, clitoris, vulva, labia, penis, and scrotum but excluding basal, epithelial, papillary, and squamous cell carcinomas of the skin.
(c) "Department" means the department of health and human services.
(d) “Reporting entity or reporting entities” means an individual, facility, or other entity described in these rules as required to report patient information with a diagnosed cancer or other reportable condition to the state cancer registry. A reporting entity includes the following:
(i) Physician as defined in sections 17001 and 17501 of the public health code, 1978 PA 368, MCL 333.17001 and 333.17501.
(ii) Dentist as defined in in section 16601 of the public health code, 1978 PA 368, MCL 333.16601.
(iii) Hospital as defined in section 20106 of the public health code, 368 PA 1978 of the public health code, MCL 333.20106.
(iv) Clinic defined as an outpatient facility that provides advice, counseling, diagnosis, treatment, surgery, care, or services relating to the preservation or maintenance of health.
(v) Clinical laboratory as defined in section 20104 of the public health code, 1978 PA 368, MCL 333.20104.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9052 Reportable Diagnoses

Rule 9052. (1) Cancer diagnoses, diagnoses of benign brain-related tumors, and any tumorous and precancerous diseases otherwise required to be reported by state or federal law shall be reported to the department in a manner consistent with these rules and procedures issued by the department.
(2) Diagnoses shall be reported by all reporting entities.
(3) A reporting entity may elect to report cases through a hospital or regional cancer registry that meets the rules set by the department.
(4) Reports shall be submitted within 180 days of a diagnosis on a form prescribed or approved by the department, except for reports forwarded on electronic media.
(5) Reports submitted on electronic media shall meet data quality, format, and timeliness standards prescribed by the department.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9053 Quality Assurance

Rule 3. (1) For the purpose of assuring the quality of submitted data, each reporting entity shall allow the department to inspect such parts of a patient's medical records as are necessary to verify the accuracy of submitted data.
(2) A reporting entity which meets the standards of quality and completeness set by the department shall be subject to inspection not more than once every 2 years for the purpose of assessing the quality and completeness of reporting from the entity.

(3) A reporting entity shall, upon request of the department, supply missing information, if known, or clarify information submitted to the department.
(4) Upon mutual agreement between a reporting entity and the department, the reporting entity may elect to submit copies of medical records instead of inspection. Each copy of a medical record or part thereof submitted to the department pursuant to this rule shall be used only for verification of corresponding reported data, shall not be recopied by the department, and shall be kept in a locked file cabinet when not being used. Such copies shall be destroyed promptly following verification of the corresponding reported data or, if the reported data appears to be inaccurate, following clarification or correction of the reported data.
(5) Both of the following provisions shall be complied with to preserve the confidentiality of each patient's medical records:
(a) Each reporting entity shall provide to the department, for inspection only, all of the following records and reports:
(i) Reports of tissue analyses which have been performed for the purpose of determining the presence or absence of malignant disease.
(ii) Reports of radiological examinations performed for the purpose of determining the presence or absence of malignant disease.
(iii) Reports of diagnoses of malignant disease and notations of the reasons for such diagnoses, including both the primary clinician's reports and consultation reports.
(iv) Those parts of medical records which contain the specific information required to be reported.
(b) A reporting entity shall not be required by this rule to allow inspection of any part of any patient's medical record other than those parts listed in subrule (3) of this rule. A reporting entity may allow the inspection of medical records from which parts, other than those specified, have been deleted, masked, crossed out, or otherwise rendered illegible.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9054 Confidentiality of Reports

Rule 4. (1) The department shall maintain the confidentiality of all reports of cancer submitted to the department and shall not release such reports, or any information which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, except in accordance with subrules (2), (3), (4), and (5) of this rule. The department shall not release any information that would indicate whether or not the name of a particular person is listed in the cancer registry, except in accordance with subrules (2), (3), (4), and (5) of this rule.
(2) A report of cancer submitted to the department concerning a particular individual, and any other information maintained in the cancer reporting system which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, shall be released as follows:
(a) To the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Presentation by the particular individual of suitable identification as required by subrule (4) of this rule.
(b) If the particular individual is a minor, to a parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the parent of suitable identification as required by subrule (4) of this rule.
(c) If the particular individual has a court-appointed guardian or if the particular individual is deceased, to the court-appointed guardian or to the executor or administrator of the particular individual's estate upon compliance with all the following provisions:

(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the guardian, executor, or administrator of suitable identification as required by subrule (4) of this rule.
(d) To an attorney or other person designated by the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(e) To an attorney or other person designated by the court-appointed guardian of the particular individual or designated by the executor or administrator of the estate of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(f) If the particular individual is a minor, to an attorney or other person designated by the parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(3) Every written request for the release of information submitted pursuant to subrule (2) of this rule shall be signed by the person making the written request. Such signature shall comply with either of the following provisions:
(a) Be witnessed by an employee of the department who has been designated to witness such requests and to whom the person making the request presents suitable identification as required by subrule (4) of this rule.
(b) Be notarized by a notary public or magistrate.
(4) Any person who is required by subrule (2) or (3) of this rule to present suitable identification shall present an identification document, such as a driver's license, or other document which contains both a picture of the person and the signature or mark of the person.
(5) The director of the department may, pursuant to R 325.9055, release information from the cancer reporting system to an authorized representative of a study or research project reviewed by the scientific advisory panel and approved by the director. The department shall not release any part of a patient's medical record obtained pursuant to R 325.9053.

History: 1985 MR 4, Eff. May 2, 1985. 5

R 325.9055 Scientific Advisory Panel; Release of Information for Research

Rule 5. (1) The director of the department shall appoint a scientific advisory panel of not less than 3 scientists to review research proposals whereby a release of information maintained by the department which identifies an individual reported to have a diagnosis of cancer is required.
(2) All research proposals which require the release of information that identifies individuals with reported diagnoses of cancer shall be reviewed by the scientific advisory panel.
(3) The panel shall, in writing, advise the director concerning the merits of the study.
(4) The release of information for research which identifies individuals with reported diagnoses of cancer shall be subject to the terms and conditions set by the department. Such study or research project shall not publish the name of any individual who is or was the subject of a report of cancer submitted to the department, and such study or research project shall not release any identifying number, mark, or description which can be readily associated with an individual who is or was the subject of a report of cancer submitted to the department.
(5) A reporting entity shall, upon notification that the director has approved a research project, provide to the department or a researcher named by the director the name of the primary physician responsible for the medical care of persons selected for the research study as indicated in the reporting entity's records.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9056 Exchange of Records

Rule 6. The department, by agreement, may transmit transcripts or copies of reports of cancer diagnoses to state or national cancer registries when the reports relate to residents of other states or countries. The agreement shall require that the transcripts or records be used for statistical purposes only as specified in the agreement and that the identity of a person subject to the report shall not be released.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9057 Rescinded

Rule 7. The publication entitled “International Classifications of Diseases for Oncology,” 1976, specified in R 325.9051 is adopted by reference in these rules. Copies of the adopted matter may be obtained from the World Health Organization Publications Center, U.S.A., 49 Sheridan Avenue, Albany, NY 12210, or from the Department of Public Health, Box 30035, 3500 N. Martin Luther King, Jr. Blvd., Lansing, Michigan 48909. At the time of adoption of these rules the cost per copy is $10.00.

History: 1985 MR 4, Eff. May 2, 1985; 2016 MR 14, Eff. March 27, 2016.

R 325.971 Reporting of Cancer

Rule 1. (1) On and after May 1, 1947, every physician, dentists, hospital superintendent, and clinic director who has knowledge of a case of cancer shall, within 10 days, report the same to the Michigan department of health on a form provided by said department. The report shall contain the name and address of the patient and either the name and address of the physician, or of the dentist, or of the hospital superintendent and hospital, or of the clinic director and clinic, and such other data as may be required.
(2) All such reports and records of the Michigan department of health pertaining to cancer are hereby declared to be confidential.

History: 1944 ACS 10. p. 16: 1954 AC. P. 2317.

Editor’s note: This rule appears in the Michigan Administrative code of 1954 as R 325.975.

Preparation of the Cancer Case Report (Abstract)

The Michigan Department of Health and Human Services (MDHHS) is mandated by Act 82 of 1984, effective July 1, 1984, to establish a cancer registry for the state of Michigan. This statute states "the department staff shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related disease in the state."

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient.

All hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the Michigan Cancer Surveillance Program (MCSP).

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985.

The MCSP Cancer Program Manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses. See sections of Introduction, Reporting Facility Terminology, Casefinding Procedures, and any other sections applicable to ensure proper and complete reporting of cancer diagnoses.

The MCSP Cancer Program Manual and other departmental documents are available on the MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program

Reporting Responsibilities

Responsibilities of Michigan Hospitals and Laboratories

- Know the MCSP reporting requirements and attend the educational workshops when rules change or deemed necessary by the quality assurance field representative.
- Select an abstract reporting option, whether on paper or electronic and establish a schedule for regular reporting.
- Notify the MCSP of any changes in the method of reporting.
    - If there are any changes in facility case count per year, notify MCSP of start date, rationale and new expected case count per year.
    - If you contract with a proprietary cancer case reporting vendor, inform MCSP of start date, vendor name and program consultant contact information (i.e., name, phone, email). Please note that it is the responsibility of the facility to ensure that the contracted vendor meets the MI cancer reporting requirements within the timeframe and format as specified by MCSP.
- Perform all casefinding activities to ensure completeness of reporting.

- Regardless of submission format (paper forms or electronic file), all reportable cases MUST be submitted to the MCSP within 180 days from the initial date of diagnosis.

- Refer to the table below to determine when abstracts are to be submitted based upon the date of diagnosis.

- Electronic data submissions are required on a monthly basis and are to be received by MCSP on or before the first working day of each month.

  Example:
  Patient diagnosed January 15, 2020.
  Case is due to the MCSP by July 2020.

  Abstract Submission Schedule for Diagnosed Cases

Month of Diagnosis…	Submit Abstract No Later Than…
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

- Inform the MCSP of ALL facility or contact person changes (e.g., mailing address, contact name, phone, email) using the "Reporting Facility Contact Information Form" on the MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program

- Facilities will be involved in periodic quality control visits by a quality improvement field representative from the MCSP. These reporting facilities will be requested to do the following:
  - Provide access to all health records as requested for quality review
  - Submit master disease index and pathology reports as requested for complete casefinding
  - Provide adequate workspace for field representatives
  - Provide access to pathology, radiation, chemotherapy, and other treatment indices for complete casefinding
  - Be available for consultation during quality control reviews and summation

- Maintain some type of accession log or master file of submissions which will serve as a quick reference of all cases sent to the MCSP. This may be as simple as keeping copies of the cancer

report forms or maintaining a reporting log which includes name, primary site, date of diagnosis, and date case was submitted to the state.

- Have access to online or printed versions of all manuals need to complete the required data items on the cancer report form or abstracting a case using Web Plus. A list of reference links to these materials can be found at the back of this manual.

Responsibilities of Physicians, Dentists and Clinics

Reporting options are as follows:

Eligible health professionals enrolled in the Medicare and Medicaid EHR incentive program may elect to report case information to the MCSP to satisfy the MCSP cancer reporting requirements. In order to select cancer reporting as a Specialized Registry Measure, eligible professionals must meet the following criteria:

- **Diagnose or Treat Cancer**
  In Michigan, all in situ and malignant conditions are reportable, with the exception of basal and squamous cell skin cancers in non-genital skin. Benign tumors of the brain and central nervous system are also reportable. For more information, see the "Reportable Conditions" section of this manual.

- **Capacity to Submit Cancer Case Reports in Standard Format**
  A national standard has been developed for certified electronic health record technology (CEHRT) to generate electronic cancer case reports. Not all CEHRTs have the capability to generate cancer cases reports using the national standard. Verification that the CEHRT has the capability is a requirement before proceeding with cancer reporting. The MCSP has developed a supplemental implementation guide CEHRT vendors should review before setting up cancer reporting for Michigan providers: Michigan Ambulatory Cancer Reporting Guide

  Eligible professionals who meet the criteria for selecting cancer reporting as the Specialized Registry Measure must complete a registration to submit cancer reports within 60 days of the start of the meaningful use reporting period Registration is completed through the Michigan Health System Testing Repository (HSTR)

  Instructions for completing the registration: Michigan Ambulatory Cancer Reporting Guide

  Once the registration is complete, an e-mail will be sent with instructions on next steps to comply with meaningful use active engagement requirements.

  View and Download the 5 Step Cancer Reporting Meaningful Use Process

1. Manual Submission

Manual submission is only available to physicians, dentists and clinics without a certified electronic health record (EHR) with less than 100 reportable conditions (cases) per year.

Cases submitted manually must use the current revision of the MCSP Cancer Report Form, which is available in PDF format and can be downloaded and/or printed from the MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program

Complete a separate cancer report form for each reportable condition and attach all applicable reports that pertains to the patient's diagnosis and/or first course of treatment of the reportable condition. For example: attestation statement, discharge summary, history and physical examination reports, pathology reports, operative reports, scopes, x-rays/scans, laboratory reports, consultation reports, treatment summary, etc.

2. Electronic Cancer Case Submission

Physicians without a certified Electronic Health Record (EHR) with more than 100 reportable conditions (cases) per year are to submit data electronically to the MCSP using the registry's Web Plus online abstracting application that collects cancer data securely over the public internet. Potential Web Plus users must complete a user request form.

Manual or Electronic Cancer Case submission of data does require a unique Michigan Facility Number, which is assigned by the MCSP.

To establish a Web Plus account and/or to obtain a Michigan Facility Number, please contact MDHHS-MCSP-WebPlus@michigan.gov

A Quality Improvement Field Representative will be assigned to the reporting entity to ensure timely, complete, and accurate submission of electronic submission of data to MCSP.

Responsibilities of the Michigan Cancer Surveillance Program (MCSP)

- Provide all reporting facilities the current cancer report form and/or software for reporting.
- Provide educational workshops and instructions to locate online reference materials.
- Perform all computer data entry of manually submitted reports and process patient data updates.
- Conduct procedures to un-duplicate the cancer patient file.
- Edit the file following NAACCR and NPCR standards.
- Clarify and resolve issues relative to data quality that are encountered during the editing process.
- Provide specific reports to verify data submission as requested by the reporting facility.
- Post an annual Cancer Incidence and Mortality statistical report on the MDHHS/Cancer Statistics web page.

Submission of Cancer Case Reports for All Reporting Types - Hospitals, Laboratories, Physicians, Dentists and Clinics

Whenever a cancer case is diagnosed or first treated within a hospital or laboratory, an abstract of the case must be prepared and forwarded to the MCSP. The abstract MUST be sent within 180 days from the initial date of diagnosis or initial treatment.

The instructions contained in this MCSP Program Manual are intended to outline what information is needed and to provide specific guidance for completing the form, and meeting state reporting requirements. Should the instructions need clarification, or if special problems exist that make reporting as outlined difficult, do not hesitate to contact MCSP to discuss the matter.

Specific instructions for identifying cases, determining primary site, assigning histology and stage are discussed in detail in sections to follow.

Upon reaching a diagnosis of an in situ or invasive cancer or providing treatment for a patient diagnosed elsewhere, a hospital or laboratory is to report the case via a paper or electronic abstract.

In addition, any tumor diagnosed October 1, 2004 or later with a behavior code of “0” or “1” for the following site codes must be reported: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3).

The abstract must be in a format provided or approved by MCSP and submitted within 180 days from the initial date of diagnosis.

- Each primary cancer diagnosed or treated within a hospital or laboratory must be reported to the MCSP on a separate cancer abstract.
- The diagnosis and/or treatment of a patient for a primary tumor that was previously reported by the facility need not be reported a second time.
- However, revisions and corrections to previously submitted information are important and should be reported to MCSP. (See “Submitting Updates (Corrections)” later in this section for instructions on how to report revisions or corrections to previously submitted abstracts.)
- New primary tumors diagnosed in previously reported patients are reportable.

As abstracts are received by the department, they will be reviewed, queried, electronically recorded and edited. In the course of assembling the data into a registry, duplicate reports of primary tumor diagnoses will be identified and tagged. The resulting file can therefore be used to develop accurate incidence information. There will be no active follow-up on the status or treatment of reported cases. MCSP maintains an incidence-based central registry – follow-up is limited to quality control issues or specific research projects.

The use of acceptable casefinding and record abstracting procedures are essential to complete reporting. The basic elements of reporting include sound casefinding techniques, correct identification of reportable cases, as well as the proper preparation and prompt submission of completed cancer reports.

Because the state maintains an incidence registry only, the information required for the state cancer report is limited compared to what is collected by a typical hospital cancer registry. Reporting of annual follow-up information on the status of a case is not necessary. However, a change in basic items of

information that identify and describe the patient or that relate to the reportable conditions with which the patient has been diagnosed must be submitted as a case report update. In addition, information regarding the types of therapy provided as the first course of therapy is also required. The instructions which follow are organized alphabetically by NAACCR data item name.

Because the majority of quality-related problems are associated with a set of essential data items, these items are routinely queried for clarification during internal quality control reviews.

Quality-related issues for certain data fields

Data Field	Typical Quality-Related Issues
Patient's First Name	• Blank • Inconsistent • Unknown • Illegible
Patient's Last Name	• Blank • Unknown • Illegible
Complete Address	• Blank • Illegible • Inconsistent
Sex	• Blank • Inconsistent with name or site
Date of Birth	• Blank • Inconsistent with site, report date, or date of diagnosis
Social Security Number	• Blank • Unknown
Primary Site	• Blank • Inconsistent with histology
Laterality	• A paired organ is reported for the primary site, but laterality is blank
Histology	• Blank • Inconsistent with the primary site • Indicates the condition may not be reportable
Stage	• Blank • Inconsistent with histology • Invalid values based on specific staging system
Method of Diagnosis	• Blank • Inconsistent, e.g., in situ diagnosis not based upon a microscopic method of diagnosis
First Course of Treatment	• Blank, but the report is from a hospital with a treatment center

If the reporting facility is unable to provide information for a required data item, the next step is to query the attending physician. For independent laboratories that do not have access to requested patient demographic information, adding the name and office address of the doctor to the abstract report is extremely helpful. Contact information about the physician should be added to the cancer report form for any case with missing information. Be sure to supply the doctor's full name, complete mailing address and phone number (if known).

Manual Submission

The cancer report (abstract) form may be typed or completed by hand. The four-page "MCSP Cancer Report Form" is available in PDF format and can be downloaded and printed from the MCSP website, https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program. Once printed, the report can be typed or completed by hand. The PDF document can also be filled out and saved when displayed on a computer monitor by using the Fill & Sign function available within Acrobat Reader.

1) **Fully completed forms are to be submitted on a monthly basis and must be submitted within 180 days from the initial date of diagnosis.** Manual submission is limited to 100 or less cases per year. Facilities with caseloads greater than 100 cases per year need written permission from MCSP to submit paper abstracts.
2) Case reports are submitted monthly to MCSP. If no case reports exist for a specified month/year, then the facility must send an email notification of this fact to
3) Completed cancer report forms and associated documents are to be submitted to MCSP through the MI Web Plus Application which requires a Web Plus account. Cancer case reports (files) are to be submitted as a Non-NAACCR File. File must be labeled according to MCSP file instructions.
4) Copies all documents that pertains to the patient's diagnosis and/or first course of treatment must accompany the MI Cancer Report Form as a combined, single PDF document. Note: Need to provide how to label a facility manual file submission and batch files so that we don't receive a upload for each individual case report.

An abstract report for each separate primary tumor is required.

Complete a separate cancer report form each reportable condition and attach all applicable reports that pertains to the patient's diagnosis and/or first course of treatment of the reportable condition. For example: attestation statement, discharge summary, history and physical examination reports, pathology reports, operative reports, scopes, x-rays/scans, laboratory reports, consultation reports, treatment summary, etc.

A second report is NOT required for a previously reportable condition if the patient is diagnosed with a recurrence that is confirmed to NOT be a second primary.

Exception: If there is no documentation within the patient's medical of the diagnosis and/or first course of treatment of the reportable condition conducted in a Michigan facility, report a cancer case report is the following information is known:

- *Date of Diagnosis:* Of the initial diagnosis of the reportable condition not the recurrence date. The year must be known as MCSP does not allow the use of the Date of Diagnosis Flag.
- *Primary Site:* Location of tumor origin not the recurrence/metastatic site.
- *Histology:* Of the initial diagnosis of the reportable condition vs the histology as reported for the confirmed recurrence.
- *Cell behavior:* For example, in situ (2) or invasive (3)
- *Laterality:* Pertains to the primary site of tumor origin.
- *Stage:* Extent of disease if known/documented within the patient's medical record.
- *First Course of Treatment:* If known/documented within the patient's medical record.
- *Text fields:* All applicable information regarding the patient's reportable condition (initial diagnosis and/or first course of treatment should be recorded in the applicable text field).

If mailed via United States Postal Service (secure tracking method), send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor
Attention: Case Reports/Mary Alana
P.O. Box 30691
Lansing, MI 48909

If shipped via commercial courier such as FedEx or UPS, send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor
Attention: Case Reports
333 S. Grand Ave., 2nd Floor
Lansing, MI 48933

Electronic Submission of Data from Hospitals and Laboratories

Hospitals and laboratories who submit more than 100 case reports per year are to submit data in electronic file format to MCSP through Web Plus.

Electronic file submission of data to MCSP through Web Plus must be in the NAACCR format version specified by MCSP.

All cancer case reports submitted to MCSP through Web Plus must be error free based upon the MI state-specific metafile specified by MCSP based upon the applicable NAACCR version format.

In order to avoid data submission backlogs, facilities who submit data in electronic file format are to submit completed cancer case reports (abstracts) on a monthly basis. Note: If the reporting entity does not have any cancer case reports to submit on a monthly basis, please remit email to:

Email: MDHS-MCSP-WebPlus@michigan.gov

Subject: Electronic file submission of data for <facility name>

Content: Casefinding for <facility name> was conducted by <full name of abstractor> for diagnosis month/year <MM/YYYY> and no reportable conditions based upon Michigan Compiled Laws and Administrative Rules on Cancer Reporting for diagnosis month/year <MM/YYYY> were identified. If you have any questions regarding this notification, please contact <name> at <phone number> or <email address>.

CoC Approved Facilities

Facilities who are approved by the Commission on Cancer (CoC) American College of Surgeons (ACoS) with an approved cancer program and/or who use proprietary cancer case reporting software are required to submit data in electronically to the MCSP through Web Plus in the format as specified by MCSP.

Do not upgrade to subsequent NAACCR version format until all reportable conditions for reporting diagnosis year are submitted in NAACCR file format specified by MCSP. To confirm NAACCR file format for electronic submission of data to MCSP through Web Plus, please remit email to MDHHS-MCSP-WebPlus@michigan.gov

Edit electronic submission of data (incidence and update file submissions) of data using the MI-state-specific metafile based upon NAACCR version format specified by MCSP.

Labeling Your Electronic Submission File

Once the export file has been created, enter a file name that begins with MI (Michigan) followed by your 5-digit Michigan Facility Number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 creates an export file on April 28, 2018. The file will be named MI9876520180428, plus the extension assigned by their software (i.e. **xva** for new case or **.xvm** for updated case reports).

If you are sending more than one file a day, please add a, b, c, etc. to the end of the file name. For example, facility 98765 sends two files on October 18, 2019:

MI9876520191018a.xva and MI9876520191018b.xva

It is important that you accurately label your file for security reasons − if a file is not accurately labeled, it cannot be loaded into the MCSP registry. **MCSP no longer accepts submissions that are incorrectly labelled.**

Electronic File Submission Instructions

1. Go to MCSP Web Plus Login page.
2. Enter your User ID and Password that was provided by MCSP.
3. Enter PIN based on your assigned Web Plus PIN Matrix
4. Select Upload File link
5. Select New Upload tab
6. Load file
   A. Select the NAACCR version of the flat file. If the version is not listed, you will need to use the NORTHCON application to convert the file to one of the listed versions. The Non-NAACCR option is only for uploading reports. Abstract files uploaded via the Non-NAACCR method will **NOT** be counted.
   B. Click the Browse button and select the file to be uploaded.
   C. Click the Upload button
7. After all records have been uploaded, an edit report will open in a new window. (Make sure your browser is set to allow pop-ups.)
8. If there are errors, you should save or print the edit report and make the necessary corrections t the applicable abstracts to clear all edit errors. If you need assistance with clearing a specific edit, please email MDHHS-MCSP-WebPlus@michigan.gov.
9. Delete the file from Web plus that contained the edit errors.
10. After the old file is deleted, generate the new, clean file and re-submit.

Non- CoC Approved Facilities and Laboratories
Facilities with 100 or more yearly cases that are not approved by the Commission on Cancer and Prevention (CoC) American College of Surgeons with an approved cancer program are to submit cancer case reports to MCSP in electronic file format through Web Plus via the online abstracting function in Web Plus.

To release cancer case reports to MCSP, the abstract must be complete, in other words, the cancer case report must be error free based upon the MI state-specific metafile for the NAACCR version format as specified by MCSP.

Web Plus

General Information

Web Plus is a web-based application that collects cancer data securely over the public internet. Web Plus supports three main functions: online abstracting, file upload and download, and follow-back efforts. Web Plus online abstracting capability is ideal for reporting from physicians' offices and other low-volume reporting sources, while the file upload feature can be used for electronic submission of data to MCSP by reporting sources. For more information, refer to

All records are saved in a database at the central cancer registry, and cases entered by one facility or office are not visible to other facilities. Data are validated by the CDC EDITS engine running on a Web server. Users, display types, and edit configurations are managed by the hosting central registry. Web Plus is hosted on a secure Web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Sockets Layer (SSL) technology.

For detailed instructions on how to access Web Plus and upload data files, refer to the *Web Plus Login and File Upload Instructions* document on the MCSP web page.

Local Administrator User Account Request Form

MCSP will establish one Local Administrator account per facility. The Local Administrator will be responsible for creating all other user accounts for the facility. To establish a Local Administrator account, complete the *MCSP Local Administrator Web Plus User Account Request Form and Acknowledgement* from the MCSP web page, https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program. Send completed form to MDHHS-MCSP-WebPlus@michigan.gov. Instructions for adding a new account and resetting a password will be provided to the Local Administrator after the form has been received. The Local Administrator will receive login information by email after the Web Plus account has been created.

If you have questions regarding Web Plus and/or completion of the *Local Administrator Web Plus User Account Request Form and Acknowledgement*, please contact MCSP via MDHHS-MCSP-WebPlus@michigan.gov.

Submitting Updates (Corrections)

Beginning January 1, 2016 MCSP requires submission of a **case report update** when changes are made to certain data items for a reported primary. This update is also referred to as an **M Record** when it is submitted electronically.

A correction to the previously submitted report MUST be forwarded when one of the following conditions occurs:

- A cancer case has been reported but is later determined to be not reportable
- Information to resolve an unknown variable has been obtained
- Information for a particular variable of a previously submitted case was later determined to be submitted incorrectly

Manual Updates (Corrections) Submission

Note: Manual updates are allowed for changes to abstracts originally submitted in paper format only.

1. Make a photocopy the cancer abstract report form that was originally submitted.
2. Draw a line through the INCORRECT information.

3. Pencil in and HIGHLIGHT the corrected information.
4. Check UPDATE in the upper right-hand corner.
5. Mail corrected cancer report forms using secure mail method, which can be tracked to MCSP.

New or altered values for the following data items require the submission of a case report update:

Field Name	Field Name (continued)
Accession Number - Hosp	Medical Record Number
Address at DX data items	Mets at DX data items
AJCC TMN Clinical data items	Name--First, Last, Middle, Birth Surname
AJCC TMN Path data items	Phase I Radiation Treatment Modality
AJCC TNM Clin Stage Group	Primary Site
AJCC TNM Path Stage Group	Race codes 1-5
Alcohol Use (State field)	Rad--Regional RX Modality
Behavior Code ICD-O-3	Reason for No Radiation
Birthplace County, State	Reason for No Surgery
Class of Case	Regional Nodes Examined
CS Data Items (2004-1015)	Regional Nodes Positive
CS Site Specific Factors (2004-2017)	Reporting Facility
Date 1st Contact	RX Date data items
Date 1st Crs RX CoC	RX Summary data items
Date Initial RX SEER	SEER SS 2000 prior to 2018
Date of Birth	Sex
Date of Diagnosis	Site Specific Data Items (SSDIs)
Diagnostic Confirmation	Social Security Number
EOD Data Items	Spanish/Hispanic Origin
Family History of Cancer (State field)	Summary Stage 2018
Grade data items	Tobacco Use (State field)
Histologic Type ICD-O-3	Tumor Size Summary 2016 and later
Laterality	Type of Reporting Source
Lymphovascular Invasion	

If mailed via United States Postal Service (secure tracking method), send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor
Attention:
P.O. Box 30691
Lansing, MI 48909

If shipped via commercial courier such as FedEx or UPS, send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor
Attention: Elaine Snyder

333 S. Grand Ave., 2nd Floor
Lansing, MI 48933

Electronic Updates (Corrections) Submission
Proprietary abstracting software designates updated abstracts as “M” records because the file suffix for these documents is .”xv**m**” rather than .”xv**a**” (new case). “M” files are uploaded to MCSP via Web Plus.

New or altered values for certain data fields require an update report submission. See Column 6 “Change Triggers M Record” beginning on page 4 of the “Reporting Requirements by Data Item and Facility Type” document on MCSP web page www.michigan.gov/mcsp https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program. Any data item in column 6 marked with an X requires submission of an M record containing the altered data value.

Update files must be error free using the MI state-specific metafile based upon version specified by MCSP.

For detailed instructions on how to access Web Plus and upload data files, refer to the Web Plus Login and File Upload Instructions document on the MCSP web page, https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program

Text Documentation

Text Documentation Instructions

Text documentation is required regardless of facility type.

An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

Text documentation is an essential component of a complete abstract and is heavily utilized for quality control and special studies. Text is required to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The purpose of text information is to provide the opportunity to review and check coded values. To accomplish this, important information that documents the disease process should be entered manually from the medical record. Another registrar should be able to completely and accurately re-abstract the case relying solely on the furnished text data. This text must not be electronically generated from the coded values, as doing so would invalidate this re-abstracting quality check.

Do not leave text fields blank. If there is no information to record in the text field, type “NR” (Not Reported) or “No Info”, By doing so, you confirm that information was sought, but none could be found; otherwise it will be assumed that the information is actually missing if the field is left blank..

Examples:

Physical Examination (PE)
2018/02/15: 49-year-old white, non-Hispanic male presenting w/enlarged prostate. Retired farmer.

Lab Tests
02/15/2018: PSA elevated 4.6 ng/ml. 2018/04/20: ER/PR positive or (+), HER2 negative or (-)

Pathology
11/12/2018 colon polyp, 1.2 x 1.0 x 0.8cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia. 2017/07/04 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x 0.9cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 1/12/18: lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative.

For guidance on the collection of supporting text, refer to NAACCR Chapter X: Data Dictionary for instructions on how to record data in text fields. (Data field names used in the MCSP Cancer Program Manual match those in the NAACCR Data Dictionary.)

Reporting Requirements by Data Item and Facility Type

Refer to “Reporting Requirements by Data Item and Facility Type” document on MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program for complete reporting instructions.

General Coding Instructions for First Course of Treatment Data Items

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. “Active surveillance” is a form of planned treatment for some patients; its use is coded in the RX SUMM--TREATMENT STATUS item. “No therapy” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code “patient refused” (code 7 or 87) for all treatment modalities.

DO NOT leave treatment items blank. If a particular treatment (or any type of treatment) was not administered, enter the “Unknown” value for that item.

Treatment Coding Guidelines and References

The National Cancer Institute provides a website that describes typical treatment modalities for a wide variety of cancer types. Additionally, as a component of its Clinical Practice Guidelines in Oncology project, the National Comprehensive Cancer Network (NCCN) posts NCCN Guidelines for Treatment of Cancer by Site.

Consult the STORE manual for general information on treatment modalities as well as specific instructions for properly coding cancer treatments including surgical procedures, radiation, and systemic therapies. Appendix B of this manual contains all surgery codes organized by primary site.

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient’s record in a Joint Commission-accredited hospital and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: “initial treatment must begin within four months of the date of initial diagnosis.”

Time Periods for First Course of Treatment

If first course treatment was provided, the Date of First Course of Treatment is the earliest of Date of First Surgical Procedure, Date Radiation Started, Date Systemic Therapy Started, or Date Other Treatment Started.

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.
- RX SUMM--TREATMENT STATUS summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias
The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

Leukemias
The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

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Follow-Up Work on Reported Cases

Contact with the reporting entity concerning an individual cancer report or a specific patient will occur under four separate circumstances. As is consistent with Administrative Rules; the cooperation of facility personnel in these four areas is essential. Should problems or concerns arise, please feel free to contact the office.

1. As cancer reports are received and processed, each will be reviewed for completeness, legibility and consistency. Contact with the reporting entity will occur to resolve identified problems in these areas as reports are initially processed and later as final processing occurs. Contacts will generally be by e-mail (with no patient identifiers) or phone. Prompt attention to such issues by the personnel responsible for completing these reports is important for smooth processing.

2. In assessing the quality of the cancer reports received from across the state, the office will contact hospitals, laboratories or registries for access to or copies of pertinent records. This is necessary in order to evaluate the quality and completeness of the information received from individual reporting entities. Problems that are identified during such reviews will be addressed as necessary to maintain or improve data quality and usefulness.

3. Contact may also occur to conduct approved epidemiological research projects. When a research study is approved by the Director of the Michigan Department of Health and Human Services, study subjects will be drawn from the state registry. Hospitals, laboratories and registries will be contacted concerning each case reported by them to ascertain the physician treating the patient. Through this process, physicians can then be contacted and patient consent obtained.

4. Unlinked Death Survey is part of the department's passive casefinding system. The Michigan Cancer Surveillance Program is required to conduct death clearance at least once a year. Through the death follow back study we add cases yearly which helps to create a more complete state cancer registry.

   Death clearance match of deaths from the official mortality file from the state, territorial, or provincial vital records office (mortality file) are linked to the registry database to identify records that match and those that do NOT match. (Note: For each patient match, the registry record is updated with death and other relevant data from the mortality file.)

   For records in the mortality file with a cancer diagnosis that did not match a central cancer registry record, the MCSP investigates to identify potentially missed incidence cases. If follow-back information is obtained, the case may be added as a missed incidence report. If no information is obtained other than the death certificate, the case is entered into the Michigan central cancer registry database as a DCO (Death Clearance Only).

   When follow-back is required, the MCSP contacts the certifying physician who signed the Certificate of Death. If no information is obtained from the physician on the cancer-related death, the MCSP conducts follow-back based upon county of death.

   If an Unlinked Death Survey is forwarded to a facility, the cancer-related death information could not be obtained from follow-back with the certifying physician, which may include follow-back of a health care provider more closely connected with the diagnosis and /or treatment of the patient.

Unlinked Death Survey Instructions

Please note! The Diagnosis Reported on the MDHHS Survey of Unlinked Cancer Deaths is **ICD-10-CM Cause of Death Code** and is NOT an ICD-O-3 topography code.

1. If a cancer case report for the cancer case death cause was abstracted by the facility, attach a copy of the abstract to the Unlinked Death Survey and return in self-addressed envelope.

2. If a cancer case report for cancer case death cause was not abstracted by the facility, review the patient's medical record(s) to determine if information regarding the patient's diagnosis and/or first course of treatment can be identified.

3. If information regarding the patient's diagnosis and/or first course of treatment can be obtained from review of the patient's medical record(s), please complete the Unlinked Death Survey and return in self-addressed envelope.

   a. Note: If the cancer-related death (cancer diagnosis) was identified as a missed report for the facility, in addition to completing the Unlinked Death Survey, please abstract the case and submit with next file submission.

4. If you are unable to provide the requested information but can provide information on a health care provider more closely connected with the patient's diagnosis and/or first course of treatment, please complete Section 3 (Referral Information) and return Unlinked Death Survey in the self-addressed envelope.

5. If you are unable to provide any information on the patient's cancer related death (or other significant condition of a cancer diagnosis contributing to death but not resulting in the underlying cause), please record **"no information"** on the Unlinked Death Survey and return in the provided self-addressed envelope.

Reportable Conditions

The first step in any casefinding effort is to outline what is reportable. The administrative rules on cancer reporting provide the definition of a reportable cancer. ALL cases satisfying this definition are reportable. The residence of the patient is NOT a factor.

Cases diagnosed on or after **January 1, 1985 to date** MUST be reported to the Michigan Cancer Surveillance Program **within 180 days from the date of initial diagnosis**.

"Cancer" means all diagnoses with a behavior code of "2" (carcinoma in situ) or "3" (malignant primary site) as listed in the most recently amended International Classification of Diseases for Oncology, EXCLUDING basal, epithelial, papillary and squamous cell carcinomas of the skin, but **including** carcinomas of the skin prepuce, clitoris, vulva, labia, penis and scrotum.

Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) are required conditions based upon Michigan Compiled Laws and Administrative Rules on Cancer Reporting, Rule 325.9052: Reportable Diagnoses.

Juvenile astrocytoma listed as 9421/**1** in ICD-O-3 are required and should be recorded as 9421/**3**, thereby making it a reportable condition.

Once a tumor has been identified, it is assigned a six-digit morphology code (e.g. 8522/34) from the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. The first four digits record the cell type or histology. The fifth digit, after the slash or solidus (/), is the behavior code and the sixth digit is the tumor grade. ALL tumors assigned a fifth digit behavior code of “2” or “3” in the ICD-O-3 are reportable.

ICD-O-3 Fifth Digit Behavior Codes for Neoplasms

Behavior Code	Definition	Reportable	Non-Reportable
/0	Benign EXCEPTION: Brain and CNS		**X**
/1	Uncertain whether benign or malignant • Borderline malignancy • Low malignant potential • Uncertain malignant potential EXCEPTION: Brain and CNS		**X**
/2	Carcinoma In Situ • Intraepithelial • Non-infiltrating • Noninvasive	**X**	
/3	Malignant, primary site	**X**	
/6*	Malignant, metastatic site • Malignant, secondary site		**X**
/9*	Malignant, uncertain whether primary or metastatic site * Not used by cancer registries.		**X**

NOTE*:* Screening of diagnostic codes for behavior codes “6 - malignant, metastatic site,” and “9 - malignant, uncertain whether primary or metastatic site” is necessary for casefinding. If this is the first diagnosis of this cancer and even though it is the metastatic site, it is still a reportable condition. The first time a diagnosis of cancer is made with an “unknown primary” it should be reported as such. If the primary site is determined after further study and it was originally reported as an unknown primary, a correction MUST be reported. The behavior code of “6” is only allowed to be used by central registries. When reporting an unknown primary site, a behavior code “3 - malignant” must be used.

Benign/Borderline Intracranial and CNS Tumors

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after **October 1, 2004** with an ICD-O-3 behavior code of “0” or “1” are required for the following sites:

- Meninges (C70.0 – C70.9)
- Brain (C71.0 – C71.9)
- Spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Those facilities approved by the American College of Surgeons (ACoS) began collecting non-malignant primary intracranial and central nervous system tumors on January 1, 2004.

For benign/borderline intracranial and central nervous system tumors, the terms “tumor” and “neoplasm” are considered clinically diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses using the terms “hypodense mass” or “cystic neoplasm” are NOT reportable.

If the final **pathologic** (tissue sample) diagnosis is “CNS neoplasm” or “mass,” there MUST be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

If only a clinical diagnosis of “CNS tumor” or “neoplasm” is available, then the case is reportable with the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

General Rules

- No timing rules for CNS neoplasms
- Laterality not used to determine multiple primaries
- Multiple cerebral meningiomas are a single primary

Laterality for CNS sites

While laterality is not considered in determining multiple CNS primaries, laterality is assigned to certain CNS sites. Per Michigan central registry rules (which follow SEER rules), the following CNS sites defined as paired for cases diagnosed 1/1/2004 and after:

- Cerebral meninges C70.0
- Cerebrum C71.0
- Frontal lobe C71.1
- Temporal lobe C71.2
- Parietal lobe C71.3
- Occipital lobe C71.4
- Olfactory nerve C72.2
- Optic nerve C72.3
- Acoustic nerve 72.4

- Cranial nerve, NOS C72.5
- Assign laterality as “0” for all other CNS sites

Reportable Pre-Invasive Cervical (C53) Conditions

Refer to documents for complete reporting instructions:

- “Case Definitions for Pre-Invasive Cervical Lesions (C53) for cases diagnosed in 2019 and later”
  or
- “Case Definitions for Pre-Invasive Cervical Lesions (C53) for cases diagnosed prior to 2019”

These documents can be downloaded from the MCSP web page:
https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program

Reportable AIN III, VAIN III, VIN III Conditions

Included Histologies

Use histology code 8077/2 for diagnoses of VIN III, VAIN III, or AIN III (Solid Tumor Rules – Rule H21).

Lesions with ICD-O-3 histology codes 8010, 8050, 8052, 8070, 8071, 8072, 8076, 8077, and 8140 are eligible for inclusion. Lesions with histology code 8560 and behavior code 2 may also be eligible if it is determined that behavior code 2 is appropriate – the pathology report should specifically indicate “in situ” behavior [since histology 8560 (adenosquamous carcinoma) is normally an invasive cancer.] An entry should be made in pathology text field to the effect that “eligibility is confirmed for this 8560 case.”

Grade

These pre-invasive lesions are to have a coded Grade/Differentiation value of 9 for cases diagnosed prior to 2018. For cases diagnosed in 2018 and later, both Grade Clinical and Grade Pathological should be coded as 9.

Number of Reportable Conditions

All types of squamous histologies (8010, 8050, 8052, 8070, 8071, 8072, 8076, and 8077) are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with these squamous histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

Histology codes 8140 (adenocarcinoma in situ) and 8560 (adenosquamous carcinoma) with behavior code 2 are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with either of these histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

A subsequent lesion is eligible for inclusion **only if its histology is different** from the first eligible lesion. If a lesion is described as having both squamous cell carcinoma in situ **and** adenocarcinoma in situ, then it should be entered as two separate abstracts, one with each histology code.

If a patient is diagnosed with another pre-invasive lesion with the same histology **after** the 12-month period following the first eligible lesion, the subsequent lesion is eligible for inclusion.

If a patient has **both** an in situ and invasive diagnosis **on the same date,** or if the invasive diagnosis follows a previously included in situ diagnosis **within 60 days,** the in-situ diagnosis is no longer considered to be eligible and should be removed from the database. However, the date of diagnosis should remain the date the in-situ tumor was diagnosed.

If a patient has an invasive tumor diagnosed **more than 60 days after** the in-situ tumor was diagnosed, then the invasive tumor is reported as a second primary tumor.

If a patient is diagnosed with a pre-invasive (in situ) lesion **within a 12-month period after** having been diagnosed with an invasive lesion, the pre-invasive lesion is not considered to be eligible for inclusion.

If separate tumors are diagnosed on the same date with differing histologies (adenocarcinoma, AIN-III), a separate abstract is to be created for each tumor per the terminology used in the pathology description.

The diagnosis must be confirmed by a positive tissue biopsy or a clinical diagnosis (physician's statement).

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
D01.3	• AIN III - high-grade anal intraepithelial neoplasia (HSIL) with or without carcinoma in-situ (CIS) is reportable • "Severe dysplasia" of anus ***alone is reportable*** • AIN II-III is reportable • AIN I, AIN II and AIN II/III is **not reportable** • "High grade dysplasia" alone is **not reportable**. Note: High grade dysplasia is reportable only with documentation of physican statement of in-situ disease.	8077/2	C21.1
D07.2	• VAIN III - high-grade vaginal intraepithelial neoplasia (HSIL) with or without carcinoma in situ (CIS) is reportable • VAIN II-III is reportable • VAIN I, VAIN II and VAIN II/III is **not reportable** • "Severe dysplasia" of vagina ***alone is reportable*** • "High grade dysplasia" of vagina ***alone is not reportable***	8077/2	C52.0-C52.9

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
D07.1	• VIN III - high-grade vulvar intraepithelial neoplasia (HSIL) with or without carcinoma in-situ (CIS) is reportable • VIN II-III is reportable • VIN I, VIN II and VIN II/III is **not reportable** • "Severe dysplasia" of vulva ***alone is reportable*** • "High grade dysplasia" of vulva ***alone is not reportable***	8077/2	C51.0-C51.9

Non-Reportable AIN I/II, CIN I/II, LSIL, VAIN I/II, VIN I/II, PIN I/II/III Conditions

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
K62.82	AIN I (anal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C21.1
K62.82	AIN II (anal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C21.1
N87.0	CIN I (cervical intraepithelial neoplasia) with or without mild dysplasia	8077/0	C53.0 - C53.9
N87.1	CIN II (cervical intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C53.0 - C53.9
N89.3	LSIL (low-grade squamous intraepithelial lesion) with or without mild dysplasia	8077/0	C53.0 - C53.9
N89.3	VAIN I (vaginal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C52.9
N89.3	VAIN II (vaginal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C52.9
N90.0	VIN I (vulvar intraepithelial neoplasia) with or without mild dysplasia	8077/0	C51.0 - C51.9
N90.1	VIN II (vulvar intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C51.0 - C51.9
N42.3	PIN I (prostatic intraepithelial neoplasia)	8077/0	C61.9
N42.3	PIN II (prostatic intraepithelial neoplasia)	8077/0	C61.9
D07.5	PIN III (prostatic intraepithelial neoplasia)	8077/0	C61.9

Reportable vs Non-Reportable Conditions of the Skin

The Michigan Cancer Surveillance Program has exclusions to the collection of skin malignancies based upon the primary site and histology.

If the following histologies arise in the skin (C44.0 - C44.9) they are NOT reportable regardless of the stage at the initial time of diagnosis.

- Malignant Neoplasm (Carcinoma), NOS of the skin 8000 - 8004
- Epithelial Neoplasms (Carcinoma), NOS of the skin 8010 - 8045
- Papillary and Squamous Cell Neoplasm (Carcinoma) of the skin 8050 - 8082
- Basal Cell Neoplasm (Carcinoma) of the skin 8090 - 8110

EXCEPTION: The above histologies must be reported if the primary site is skin of the male and female genital sites. See “Reportable vs. Non-Reportable Conditions of the Skin” table below.

ALL other histologies of the skin ARE REPORTABLE, e.g.: melanoma, Kaposi sarcoma, mycosis fungoides, cutaneous lymphomas, Merkel cell carcinoma, etc.

Table: Reportable vs Non-Reportable Conditions of the Skin

ICD-10-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C52	Skin of vagina	C52.9	X	
C51.2	Skin of labia majora	C51.0, C51.1	X	
C51.1	Skin of labia minora	C51.1	X	
C51.2	Skin of clitoris	C51.2	X	
C51.9	Skin of vulva, NOS	C51.9	X	
C57.8	Skin, overlapping lesion	C51.9	X	
C60.0	Skin of prepuce	C60.0	X	
C60.9	Skin of penis, NOS	C60.9	X	
C63.2	Skin of scrotum (does not include HSIL 8077/2)	C63.2	X	
C44.00 C44.01 C44.02 C44.09	***Skin of lip (see note below)**	C44.0		X
C44.101 C44.111 C44.121 C44.191	Skin of eyelid/other unspecified parts of the face	C44.2		X
C44.201 C44.211 C44.221 C44.291	Skin of external ear/auditory canal	C44.2		X
C44.300 C44.301 C44.309 C44.310 C44.311 C44.319 C44.320 C44.321 C44.329 C44.390 C44.391 C44.399	Skin of other & unspecified parts of the face	C44.3		X
C44.40 C44.41 C44.42 C44.49	Skin of scalp and neck	C44.4		X
C44.509 C44.519 C44.529 C44.599	Skin of trunk	C44.5		X

ICD-10-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C44.601 C44.611 C44.621 C44.691	Skin of upper limb and shoulder	C44.6		X
C44.701 C44.711 C44.721 C44.791	Skin of lower limb and hip	C44.7		X
C44.80 C44.81 C44.82 C44.89	Skin, overlapping lesion	C44.8		X
C44.90 C44.91 C44.92 C44.99	Skin, NOS	C44.9		X

Note: *Skin of the lip:

- The codes for the mucoepidermoid portions of the lip are C00.0 - C00.9. These include the inner mucosal surface of the lip, the vermilion surface of the lip (the area where lipstick is applied and the vermilion border of the lip). Report these C00 cases.
- C44.0 is the code for the SKIN of the upper lip between the vermilion border and the nose and SKIN of the lower lip between the vermilion border and the chin. DO NOT report these C44 cases.

Cancer Case Reportability Scenarios

The following scenarios and definitions are to assist with determining whether or not the patient has a reportable condition.

Reportable Case Scenarios

1. If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the pathologist, the case is reportable.

2. If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the managing physician, the case is reportable.

3. If a specimen is sent to your facility from a staff physician’s office and read by your pathologist (e.g., stereotactic needle biopsy for a breast mass, or excisional biopsy positive for malignant melanoma) the case is to be reported.

4. An incidental finding of a malignancy at the time of an autopsy, with no suspicion of cancer prior to death, MUST be reported.

5. All malignant histologically confirmed specimens identified by your facility, e.g., tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage (D&C); bone marrow biopsy, bone marrow aspiration; hematologic confirmation of leukemia (peripheral blood smear); loop electrocautery excision procedure (LEEP), are reportable.

6. All malignant cytological confirmed specimens identified by your facility, e.g.,, breast secretion, bronchial brushing, bronchial washings, cervical smear (pap smear), fine needle aspirate (FNA), gastric fluid, peritoneal fluid, pleural fluid, prostatic secretions, spinal fluid, sputum smears, tracheal washings, urinary sediment, vaginal smears, are reportable.

7. Patient is diagnosed in a staff physician's office and treated at your facility.

8. Patient is diagnosed at your facility and treated elsewhere, whether by referral or by choice.

9. Patient is diagnosed at your facility and receives all or part of his/her treatment at your facility.

10. Patient is diagnosed at your facility and refuses therapy.

11. Patient is diagnosed at your facility and the family/guardian refuses therapy.

12. Patient is diagnosed at your facility and is untreatable due to age, advanced disease or other medical conditions.

13. Patient is diagnosed at your facility and specific therapy was recommended but not received at your facility or unknown if administered.

14. Patient was diagnosed elsewhere but received all or part of his/her treatment at your facility.

15. Patient is diagnosed at your facility but unknown if therapy was recommended or administered.

16. Patient was diagnosed by death certificate only.

17. Patient receives all or part of the first course of therapy for a malignancy, regardless of where they were first diagnosed.

18. Patient is a non-resident of Michigan and is receiving treatment at your facility.

19. Patient is a Michigan resident diagnosed out of state but receiving treatment at your facility.

20. Patient is a Michigan resident diagnosed and treated out of state, e.g., The patient is diagnosed and treated in Wisconsin for breast cancer, but is admitted to the cardiac care unit at your facility. You recognize that the patient has breast cancer and is receiving their first course of treatment in Wisconsin. The patient is a Michigan resident; therefore the case is reportable.

Non-Reportable Case Scenarios

1. Precancerous or benign conditions (except benign or borderline intracranial CNS tumors diagnosed on or after October 1, 2004).

2. Patients seen only in consultation to establish or confirm a diagnosis of cancer or treatment plan when the patient was first seen in a known Michigan facility.

3. Patient is diagnosed with a recurrence or progression of a previously diagnosed malignancy. Note: Consult Solid Tumor Rules effective 1/1/2018 under General Instructions/Timing Rule on usage of the term “recurrence.”

   Exception: If your facility did not submit a cancer case report for the initial diagnosis of the reportable condition and there is no documentation within the patient’s medical record that the diagnosis and/or first course of treatment was performed in a Michigan facility, report the non-analytic case report to MCSP if the sufficient information (as defined below) is available within the patient’s medical record. Extent of disease and first course of treatment is helpful; however, it is not required in order to report the non-analytic type of case report to MCSP.

   Sufficient information is defined as follows:
   - Patient’s Last Name and First Name
   - Patient’s Date of Birth
   - Patient’s address
   - Date of Diagnosis: At a minimum, the year of initial diagnosis must be known. Note: MCSP does not allow the use of the Date of Diagnosis Flag.
   - Primary Site: The site of tumor origin of the initial diagnosis of the reportable condition.
   - Histology: Report the histology of the initial diagnosis of the reportable condition not the recurrence.
   - Cell behavior: If stage of disease is unknown, record cell behavior as invasive (3) and accurately indicate in the applicable text field that extent of disease information of the initial diagnosis of the reportable condition is unknown (i.e. in situ vs invasive).

4. The patient’s malignancy was originally diagnosed prior to January 1, 1985.

5. Patient receives a radiographic exam (MRI, X-ray, CT) which reveals an ill-defined “mass.” If the patient does NOT return to your facility for diagnostic confirmation or treatment of cancer, the case is not reportable. For example: an outpatient CT scan of the pelvis reads, probable carcinoma of the right kidney. The patient did not return to your facility for diagnostic confirmation or treatment; therefore, the case is not reportable.

   NOTE: In order for a “radiographic diagnosis” to be reportable, the patient’s primary care physician MUST state in the medical record that the patient has cancer and treatment has been decided upon. Keep in mind, that refusal of treatment and the decision not to treat is still classified as treatment and the case is to be reported.

6. Patient visits your facility for blood work (lab only) and is NOT admitted for treatment, e.g., blood drawn to monitor anemia for patients receiving chemotherapy elsewhere; blood drawn to monitor PSA levels for prostate cancer.

7. Patient has an active malignancy but is admitted to your facility for an unrelated medical condition and does not receive first course of treatment for their cancer.

8. Patient is admitted to your facility with an active malignancy and receives supportive or palliative care, e.g., gastrostomy tubes for enteral nutrition, if previously reported or diagnosed/treated through another Michigan hospital.

9. Patients with a history of cancer who are clinically free of disease.

10. Patients admitted for terminal supportive care, including home care services, if previously reported or diagnosed/treated through another Michigan hospital.

11. Patients admitted to a designated hospice, if previously reported or diagnosed/treated through another Michigan hospital.

12. Patient's specimen slides are sent to your pathologist for a second opinion.

13. Patients with skin cancer that does NOT meet the histology and site requirements listed previously.

Facility Specific Case Scenario

Your facility may receive specimens from a separate facility that are read by your pathologist due to the facility not having a pathologist or a laboratory. Once the specimen is read, the final report and specimen(s) are sent back to the original facility. You may or may not be responsible for reporting the ones that are malignancies. A verbal or written contract between the two facilities must exist that designates which facility will be responsible for reporting these cases to the Michigan Cancer Surveillance Program. If an agreement does NOT exist, BOTH facilities are expected to report each case.

Ambiguous Terminology

As part of the registry case-finding activities, ALL pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms **do not** constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.

Ambiguous terms may originate from any source document, such as pathology report, radiology report, or from a clinical report. However, do not report cases diagnosed only by ambiguous cytology. (See Note 6 below.)

NOTE: The ambiguous terms in this section are used to determine diagnostic reportability to MCSP. The following list is NOT used to determine multiple tumors or AJCC TNM Staging.

- Consult the Solid Tumors Rules manual and appropriate AJCC TNM Staging Manual for allowable terminology.

- See "Ambiguous terminology for hematopoietic and lymphoid neoplasm" heading on next page for information concerning non-solid tumors.

Ambiguous terms that **constitute a diagnosis:**

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favors
- Malignant appearing
- Most likely
- *Neoplasm (only applies to sites C70.0 - C72.9 and C75.1 - C75.3 diagnosed 2004 and later)
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- *Tumor (only applies to sites C70.0 - C72.9 and C75.1 - C75.3 diagnosed 2004 and later)
- Typical of

Note: * these terms apply to nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If a cytology is identified only with an ambiguous term, **do not** interpret it as a diagnosis of cancer.

- Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples:

The inpatient discharge summary documents a chest X ray consistent with carcinoma of the right upper lobe. The patient refused further work-up or treatment.
"Consistent with carcinoma" is indicative of cancer.

The mammogram report states "suspicious for malignancy."

"Suspicious for malignancy" is indicative of cancer.

Ambiguous terms that **do not constitute a diagnosis without additional information:**

- Cannot be ruled out
- Equivocal
- Possible
- Potentially malignant
- Questionable
- Rule out
- Suggests
- Worrisome

Examples of non-diagnostic terms:

The inpatient discharge summary documents a chest x-ray consistent with neoplasm of the right upper lobe. The patient refused further work-up or treatment.
"Consistent with neoplasm" is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not considered diagnostic except for non-malignant primary intracranial and central nervous system tumors.

Final diagnosis is reported as possible carcinoma of the breast.
"Possible" is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of **risk only** and **do not** constitute a diagnosis.

Ambiguous terminology for hematopoietic and lymphoid neoplasm
Apply the following terminology to non-solid tumor cases diagnosed in 2010 and later. Report the case when the diagnosis of a hematopoietic or lymphoid neoplasm is preceded by one of the following ambiguous terms. For additional information, refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual.

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note 1: Use these terms when screening all reports other than cytology and tumor markers.

Note 2: Report cases that use only the words on the list or an equivalent word such as "favored" rather than "favor(s)". Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable with." Do not substitute "likely" for "most likely." See SEER coding manual - Reportability section.

Note 3: Accept the reportable term and report the case when one part of the medical record uses a reportable ambiguous term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list.

Note 4: Follow back is recommended for diagnoses based on ambiguous terminology to see if the diagnosis has been confirmed or proven to be incorrect (see note 5).

Note 5: Do not report the case when biopsy or physician’s statement confirms a non-reportable condition or proves the ambiguous diagnosis is wrong.

Example: CT scan shows enlarged lymph nodes suspicious for lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. The pathology is more reliable than the scan; the negative biopsy proves that the ambiguous diagnosis was wrong. Do not report the case.

Note 6: Do not report cases diagnosed only by ambiguous cytology (cytology diagnosis preceded by ambiguous term).

Example: Parotid ultrasound guided FNA: consistent with non-Hodgkin’s lymphoma. This case was diagnosed based on cytology/fine needle aspiration (FNA) preceded by ambiguous terminology (consistent with). Do not report this case based on ambiguous cytology.

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Casefinding Procedures

Casefinding is a systematic process used to identify all cases eligible to be included in the central cancer registry. Cases include those patients that were diagnosed and/or treated with a reportable condition in your facility.

One source for casefinding is not enough to identify all cancer cases diagnosed or treated at your facility and multiple sources must be used to obtain a complete description of each patient's course of cancer care.

At a minimum facilities, need to conduct reviews of MDI and pathology reports (benign and malignant) to determine all reportable conditions as well as investigating other sources listed below as applicable based on facility type.

Each facility should have written procedures and instructions for carrying out complete casefinding. This will ensure that casefinding is performed on a regular basis and allow personnel to know the status of casefinding at all times. A written log or tracking system should be in place to monitor all casefinding sources. Casefinding sources may be monitored daily, weekly, monthly, or quarterly.

Having a system for recognizing reportable conditions is essential to complete reporting. A process which will identify all cancer cases that are diagnosed or treated within a facility must be devised. All pertinent medical records which may contain information on any case of diagnosed cancer must be reviewed, whether that diagnosis is clinical or histological. The hospital where a diagnosis is reached or a patient is treated must endeavor to report all cases regardless of the patient's status. This includes outpatients and patients diagnosed elsewhere when the place of diagnosis is unknown or is outside the state. An independent laboratory must similarly ascertain needed information upon determining that a reportable condition exists. It is important to report all patients, including patients who do not live in Michigan.

Patients who were diagnosed elsewhere and newly admitted to your facility for further treatment, are to be reported provided the first diagnosis occurred after the start date of the state registry on January 1, 1985. This may result in multiple reports on one patient, but it will enable the MCSP to have the most comprehensive data on each case and serves as a quality control mechanism.

Cancer registries should first examine the sources used to identify malignant CNS tumors and expand the procedures to include non-malignant CNS tumors.

Since surgery is often the treatment for CNS tumors of all behaviors, pathology reports are an excellent casefinding source. Inpatient and outpatient surgery logs should also be reviewed. Many patients with CNS tumors of all behaviors are treated with adjuvant radiation therapy and review of radiation oncology appointment logs is a way to identify these cases.

Gamma/cyber knife is becoming a common treatment for non-malignant CNS tumors. If the hospital has a gamma/cyber knife center, review logs and schedules as part of casefinding. Hormone therapy and immunotherapy are medical treatments given for both non-malignant and malignant CNS tumors.

Reports are necessary for outpatients who are diagnosed as having cancer based upon a laboratory diagnosis of submitted specimens as well as those cases where outpatient surgery is the only means of diagnosis. Outpatients initially treated for cancer who were not diagnosed within a facility should also be reported if receiving outpatient radiotherapy or chemotherapy.

A report is not required when initially treating a patient diagnosed elsewhere if it is known that the patient was first diagnosed and treated in some other Michigan hospital, and you have the name of the diagnosing hospital in the medical record. Patients that have been diagnosed out of state e.g., Mayo Clinic or in an unknown facility, who come to your facility for treatment must be reported. This requirement includes the reporting of “historic” cases that otherwise meet the definition of a reportable case.

In many facilities, these functions and/or record systems are coordinated which can greatly simplify the process of casefinding. What is important, is that all sources of information pertinent to case identification must be reviewed. The development of a coordinated screening of these various files is essential to assuring complete reporting.

A second report is not necessary upon confirmation or re-diagnosis of a specific primary tumor or the metastasis therefrom, if that specific primary is known to have been reported earlier. Send a second report only if the information first reported on the patient requires correction or can be reported more completely than previously known.

It is very important to report all cases regardless of state residency. Data on all cancer cases is of value in several ways. In particular, Michigan currently has resident data exchange agreements with several states concerning cancer cases diagnosed and/or treated within our respective borders. Michigan sends reports of nonresident patients to their state of residency and these states reciprocate by sending MCSP records of MI residents diagnosed or treated for cancer in their state.

When in doubt about submitting a cancer case to the Michigan Cancer Surveillance Program (MCSP), ask these three questions:

1. Does the patient have a diagnosis of cancer that is reportable?
2. Is it a new reportable condition?
3. Was the case diagnosed since the start date of the central registry January 1, 1985?

If the answer is yes to these questions and the case has not yet been submitted by your hospital, report the case.

If you have questions about a particular case, submit the case with an attached note of explanation or call the state registry.

A record of those cases submitted to the central state registry must be maintained. It is recommended for those facilities that submit manually, to make a copy of the completed cancer report form, submit the original form to the state central cancer registry and file the copy alphabetically by last name combining all diagnosis years. For those facilities that submit electronically, a list of cases submitted to the state central cancer registry can easily be generated via the software.

The MCSP recommends retaining copies of the cancer report forms or submission log for a period of three full years. Legislation indicates that an audit may be conducted “not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting.” During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit process.

If a submission log is maintained, it should contain at a minimum, the following items: patient’s full name, medical record number, social security number, date of birth, date of diagnosis, primary site, laterality and summary stage. The submission log is not necessarily the best mechanism for keeping

track of those cases submitted to the MCSP, but those facilities that wish to maintain a log are free to do so.

Examples and definitions of sources for casefinding are as follows:

Pathology Reports

Review all pathology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

If the final pathologic diagnosis is “CNS neoplasm” or “mass,” there must be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is not reportable.

If the only diagnosis available is “CNS tumor” or “neoplasm” the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

This includes specimens sent to your facility from physician’s offices to be read by the hospital pathologist.

Cytology Reports

Review all cytology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

This includes pap smears, or specimens sent to your facility from a physician’s offices to be read by the hospital pathologist.

Bone Marrow Reports

Review all bone marrow reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

Autopsy Reports

Review all autopsy reports from the pathology department at least twice a year. Review all diagnoses recorded, not just the cause of death, as occult or unexpected malignancies can be found on autopsy reports. If your facility does not perform autopsies, these reports may be located in the health information department.

Medical Oncology Logs (Chemotherapy)

Chemotherapy is administered either as an inpatient, outpatient, in a free-standing facility or a physician’s office. Develop a system for identifying patients who receive chemotherapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

Radiation Oncology Logs

Radiation therapy is administered either as an inpatient, outpatient or in a free-standing facility. Develop a system for identifying patients who receive radiation therapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

Radiology

Review CT scans of the head, MRI's of the head and any additional scans of the head to identify reportable benign conditions of the brain and/or central nervous system. Review the reports from radiology on a monthly or quarterly basis.

For benign/borderline intracranial and central nervous system tumors, the terms "tumor" and "neoplasm" are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses like "hypodense mass" or "cystic neoplasm" are NOT reportable even for CNS sites.

Master Disease Index (MDI)

Generate a MDI on a monthly or quarterly basis by discharge date which is based upon the diagnosis year.

Use the applicable ICD-CM codes from casefinding list to generate the MDI.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude laboratory visits. Include radiology visits only for benign/borderline brain/CNS tumors.**

List the principle code, primary code and secondary codes to include up to six diagnostic codes that have been assigned.

The MDI should include the following items: last name, first name, middle initial, date of birth, social security number, medical record number, laboratory number (if applicable), admit date, discharge date, patient type, the six ICD-CM codes and ICD-CM code descriptions that have been assigned.

Once the MDI has been generated, it must be compared with the log (or copies) of previously submitted cases. Sort the MDI alphabetically by last name. This will make it easier when comparing the MDI to previously submitted cases.

If the name from the MDI appears on the log of previously submitted cases, determine whether this is a new primary, recurrence or progression of disease from the original primary. (Refer to the Multiple Primary and Histology Coding Rules for clarification.)

- A separate report must be submitted for each new primary.
- Additional reports for recurrence or progression of disease should not be included.

If the name from the MDI does not appear on the log of previously submitted cases, determine whether this a new case, missed case or non-reportable condition.

- A separate report must be submitted for a new or missed case.
- If a non-reportable condition exists, document on the MDI next to the patient's name the condition that was determined to be non-reportable. This will be helpful when reviewing future MDI's.

Examples:

John Doe

NR SCC skin (non-reportable squamous cell carcinoma)
James Doe
NR recurrent bladder cancer

Based upon your facility's needs, it may be beneficial to maintain a separate log of those cases determined to be non-reportable. This can easily be achieved by completing the demographic information only on the cancer report form and documenting the non-reportable condition in the primary anatomical site field.

The MCSP recommends retaining the MDI log for a period of **three full years**. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit.

The tables that follow illustrate the applicable ICD-CM codes that should be used to generate the Master Disease Index (MDI).

ICD-9-CM Casefinding List Effective Through September 30, 2015 Only

Table: ICD-9-CM Casefinding List Effective Through September 30, 2015 Only

ICD-9-CM Code	Explanation of Code
140.0 – 172.9, 174.0 – 208.9	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
209.0 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: • High grade neuroendocrine carcinoma, any site • Malignant poorly differentiated neuroendocrine tumor, NOS, any site
209.31 – 209.36	Merkel cell carcinoma **NOTE**: Effective date 10/1/09
209.70 – 209.74	Secondary neuroendocrine tumors **NOTE:** Effective Date 10/1/09 Reportable inclusion terms: • Secondary carcinoid tumors **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.75	Secondary Merkel cell carcinoma Reportable inclusion terms: • Merkel cell carcinoma nodal presentation • Merkel cell carcinoma visceral metastatic presentation • Secondary Merkel cell carcinoma, any site **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.79	Secondary neuroendocrine tumors of other sites **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
225.0 – 225.9	Benign neoplasm of brain and other parts of nervous system

ICD-9-CM Code	Explanation of Code
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: • Benign neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
227.4	Benign neoplasm of pineal gland (pineal body)
227.9	Benign neoplasm of unspecified endocrine gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: • Angioma, NOS • Cavernous nevus • Glomus tumor **NOTE:** Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.
228.1	Lymphangioma, any site **NOTE:** Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
230.0 – 234.9	Carcinoma in situ Reportable inclusion terms: • Cervical Intraepithelial neoplasia, Grade III • Erythroplasia, Queryrat's • AIN III, CIN III, VAIN III, VIN III
237.0 – 237.1	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
237.5, 237.6, 237.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
238.4	Polycythemia vera (9950/3): Excludes: • Familial polycythemia (D75.0) • Secondary polycythemia (D75.1)
238.6	Plasma cells
238.7	Other Lymphatic and Hematopoietic tissues **NOTE:** This code was expanded in 10/2006. It is now a subcategory and is no longer valid for coding purposes; however, it should be included in extract programs for quality control purposes.
238.71 – 238.77, 238.79	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues

ICD-9-CM Code	Explanation of Code
239.6, 239.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system **NOTE:** Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term “mass,” unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: • ‘growth, NOS’ • ‘neoplasm, NOS’ • ‘new growth, NOS’ • ‘tumor, NOS’ • ‘neoplasm of uncertain behavior” (D37-D44, D48) Excludes: • Neoplasm of unspecified behavior of cerebral meninges (D49.7) • Neoplasm of unspecified behavior of cranial nerves (D49.7) • Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
273.2	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: • Franklin’s disease (heavy chain) (9762/3) • Heavy chain disease (9762/3) • Mu-chain disease (9762/3)
273.3	Macroglobulinemia (Waldenstrom’s macroglobulinemia)
277.89	Other specified disorders of metabolism Reportable inclusion terms: • Hand-Schuller-Christian disease • Histiocytosis (acute) (chronic) • Histiocytosis X (chronic) [OBS] • Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
285.0	Sideroblastic anemia Reportable inclusion terms: • Acquired idiopathic sideroblastic anemia • Pure sideroblastic anemia • Refractory anemia with hemochromatosis • Refractory anemia with sideroblasts • Refractory anemia with ringed sideroblasts (RARS) • Sideroblastic anemia
288.3	Eosinophilia **NOTE**: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is: • Chronic eosinophilic leukemia (CEL) • Chronic eosinophilic leukemia (and the hyperosinophilic • syndrome) • Hypereosinophilic (idiopathic) syndrome (HES)
288.4	Hemophagocytic syndromes (Histiocytic syndromes)
289.6	Familial polycythemia (synonym for polycythemia vera)
795.04	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy

ICD-9-CM Code	Explanation of Code
795.14	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
795.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will continue to report these cases and code behavior as /3 (malignant).

ICD-10-CM Casefinding List Effective October 1, 2015 and Later.

Table: ICD-10-CM Casefinding List Effective October 1, 2015 and Later

ICD-10-CM Code	Explanation of Code
C00.0 – C43.9, C45.0 – C96.6, C96.9, C96.A, C96.Z	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
C4A._	Merkel cell carcinoma **NOTE:** Effective date 10/1/09
C75.0	Familial polycythemia (synonym for polycythemia vera)
C7A.00 – C7A.098	Neuroendocrine tumors
C7A.1, C7A.8	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: • High grade neuroendocrine carcinoma, any site • Malignant poorly differentiated neuroendocrine tumor, NOS, any site
C7B.00 – C7B.04, C7B.09	Secondary neuroendocrine tumors **NOTE:** Effective Date 10/1/09 Reportable inclusion terms: • Secondary carcinoid tumors **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.1	Secondary Merkel cell carcinoma Reportable inclusion terms: • Merkel cell carcinoma nodal presentation • Merkel cell carcinoma visceral metastatic presentation • Secondary Merkel cell carcinoma, any site **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.8	Secondary neuroendocrine tumors of other sites **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C88.0	Macroglobulinemia (Waldenstrom's macroglobulinemia)

ICD-10-CM Code	Explanation of Code
C96.5, C96.6	Other specified disorders of metabolism Reportable inclusion terms: • Hand-Schuller-Christian disease • Histiocytosis (acute) (chronic) • Histiocytosis X (chronic) [OBS] • Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
D00.00 – D03.9, D05.00 – D09.9	Carcinoma in situ Reportable inclusion terms: • Cervical Intraepithelial neoplasia, Grade III • Erythroplasia, Queryrat's • AIN III, CIN III, VAIN III, VIN III
D18.1	Lymphangioma, any site **NOTE:** Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
D18.02	Hemangioma; of intracranial structures Reportable inclusion terms: • Angioma, NOS • Cavernous nevus • Glomus tumor **NOTE:** Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.
C71.0 – C72.9	Malignant neoplasm of brain and other parts of nervous system
C75.1	Malignant neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: • Malignant neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
C75.3	Malignant neoplasm of pineal gland (pineal body)
C75.9	Malignant neoplasm of unspecified endocrine gland
D42.0, D42.1, D42.9, D43.2, D43.3, D43.4, D43.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
D44.3 – D44.5	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
D45	Polycythemia vera (9950/3): Excludes: • Familial polycythemia (D75.0) • Secondary polycythemia (D75.1)
D46.0 – D46.2, D46.20 – D46.22, D46.A, D46.B, D46.C, D47.3, D46.9, D47.1, D47.Z1, D47.7, D47.9, D47.Z9	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues
D47.Z9	Plasma cells

ICD-10-CM Code	Explanation of Code
D49.6, D49.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system **NOTE:** Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term "mass," unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: • 'growth, NOS' • 'neoplasm, NOS' • 'new growth, NOS' • 'tumor, NOS' • 'neoplasm of uncertain behavior" (D37-D44, D48) Excludes: • Neoplasm of unspecified behavior of cerebral meninges (D49.7) • Neoplasm of unspecified behavior of cranial nerves (D49.7) • Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
D64.0 – D64.3	Sideroblastic anemia Reportable inclusion terms: • Acquired idiopathic sideroblastic anemia • Pure sideroblastic anemia • Refractory anemia with hemochromatosis • Refractory anemia with sideroblasts • Refractory anemia with ringed sideroblasts (RARS) • Sideroblastic anemia
D72.1	Eosinophilia **NOTE:** This code is for eosinophilia, which is not reportable. **Do not** abstract unless diagnosis is: • Chronic eosinophilic leukemia (CEL) • Chronic eosinophilic leukemia (and the hyperosinophilic • syndrome) • Hypereosinophilic (idiopathic) syndrome (HES)
D76.1 – D76.3	Hemophagocytic syndromes (Histiocytic syndromes)
D89.1	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: • Franklin's disease (heavy chain) (9762/3) • Heavy chain disease (9762/3) • Mu-chain disease (9762/3)
R87.613	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
R87.614	Papanicolaou smear of cervix with cytologic evidence of malignancy
R87.623	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
R87.624	Papanicolaou smear of vagina with cytologic evidence of malignancy
R85.613	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
R85.614	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will continue to report these cases and code behavior as /3 (malignant).

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude all laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors only:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

Benign/Borderline Intracranial and CNS Tumors Casefinding List

Due to a change in the federal law affected by passage of Public Law 107-260, which requires the collection of case information for benign brain and CNS tumors, revisions to the administrative rules that govern Michigan cancer reporting have been made. Reporting of benign brain and CNS related tumors is now required. This new requirement is effective with cases diagnosed on October 1, 2004 forward.

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after October 1, 2004 with an ICD-O-3 behavior code of “0” or “1” are required for the following sites:

- Meninges (C70.0 – C70.9)
- Brain (C71.0 – C71.9)
- Spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3).

Juvenile astrocytomas should continue to be reported as 9421/3.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude all laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors only:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

Casefinding List for Benign/Borderline Intracranial and Central Nervous System (CNS) Tumors

ICD-9-CM Code	ICD-10-CM Code	ICD-O-3 Code and Description
225.2	D32.0	C70.0 Cerebral meninges
225.4	D32.1	C70.1 Spinal meninges

ICD-9-CM Code	ICD-10-CM Code	ICD-O-3 Code and Description
237.6	D42.0, D42.1, D42.9	C70.9 Meninges, NOS
225.0	D33.0, D43.0	Brain - Supratentorial: • C71.0 Cerebrum (Supratentorial, NOS) • C71.1 Frontal lobe • C71.2 Temporal lobe • C71.3 Parietal lobe • C71.4 Occipital lobe • C71.5 Ventricle ○ Includes: ▪ Ventricle, NOS ▪ Cerebral ▪ Lateral ▪ Third ○ Excludes: Fourth ventricle
225.0, 237.5	D33.1, D43.1	Brain - Infratentorial: • C71.6 Cerebellum, NOS • C71.7 Brain stem • C71.7 Fourth ventricle
225.0, 237.5	D33.1 – D33.9, D43.2	C71.8 Overlapping lesion of brain
225.0, 237.5	D33.2, D43.2	C71.9 Brain, NOS
225.3, 237.5	D33.4, D43.4	C72.0 Spinal cord C72.1 Cauda equina
225.1	D33.3, D43.3	Nerves - Olfactory, optic, acoustic, NOS: • C72.2 Olfactory nerve • C72.3 Optic nerve • C72.4 Acoustic nerve • C72.5 Cranial nerve, NOS
225.8, 225.9, 237.9	D33.7, D33.9, D43.8, D43.9	C72.8 Overlapping lesion of brain and CNS C72.9 Central nervous system, NOS: • Other specified sites of nervous system • Nervous system, part unspecified
227.3, 237.0	D35.2, D44.3	C75.1 Pituitary gland
227.3, 237.0	D35.3, D44.4	C75.2 Craniopharyngeal duct
227.4, 237.1	D35.4, D44.5	C75.3 Pineal gland

Components of Good Reporting

Quality control field projects carried out within Michigan have been designed to measure the completeness and accuracy of the cancer data as well as timeliness of reporting. The results indicated the following quality control problems that need to be addressed if a facility is to satisfy the obligation to report all cancer cases. These issues are identified separately with recommendations that would help avoid reporting problems. The topics are discussed below and are divided into those that affect casefinding and those that affect the accuracy of reports.

Casefinding Problems

- **Completeness** Reporting responsibility placed solely in the pathology department results in cases being missed that are diagnosed through other means. This especially pertains to cases involving the primary sites of the trachea, bronchus, pancreas, brain or lung, chronic leukemia and lymphoma. In hospitals with no tumor registry there needs to be an established procedure that ensures all cases are reported. These procedures must **include every department in the hospital which deals with cancer patients**. A procedure for reporting should be in place within all departments involved in either diagnosing or treating cancer patients. One approach is to develop a communication system between each department, and the group coordinating reporting, by placing one person in charge of reporting across all departments. Training staff within each area to follow coordinated procedures will eliminate missing cases. This should be covered within the written procedures on reporting in place within each facility.

- **Registries in Transition** Hospital cancer registries changing from manual reporting to a software system, or updating to a new software system, tend to have more missing cases. The registry staff while learning the new software system abstracts into the hospital registry while continuing to report manually this can be confusing and can result in cases that need to be sent to the state registry being overlooked. During a transition stage **a procedure needs to be developed which will ensure all cases are properly reported**. One approach is to maintain a log of reported cases, or some type of recording system, to allow comparison between the cases in the hospital registry and those cases sent to the central registry. The log needs to be updated and checked on a monthly basis through this transition period.

- **Class of Case** All approved hospital registries classify cases as analytical or non-analytical. Sometimes registries mistakenly send only the analytical cases. Completeness of reporting is improved by registries being sure they are sending **all cancer patient data regardless of class of case**. Though this may result in duplication, it is the best way to ensure that all cases are reported to the state and none are skipped due to confusion on a patient's status. The MCSP accepts all cases regardless of their class of case status.

- **Reporting Outpatient Cases** Outpatient cases can be overlooked by reporting facilities due to a lack of communication and lack of a reliable reporting system within the facility. It is important to establish a referral procedure that will identify and prompt the reporting of **all outpatient cancer cases which are diagnosed or treated in your facility, clinics operated by your facility or through an affiliated laboratory**. Reporting personnel should set up a reporting system with personnel having access to outpatient records relative to outpatient treatment and outpatient diagnosis. It is important to include diagnostic work for specimens submitted to the laboratory in this process. Outpatient cancer case information can be reported independently, or preferably, routed to the personnel responsible for all cancer case reporting. This should be done on a regular basis, i.e., weekly or daily depending upon the size of the hospital, to insure timeliness of reporting and to avoid backlogs.

- **Reporting Michigan Residents Diagnosed Out of State** Michigan residents diagnosed out of state but receiving treatment in a Michigan hospital can mistakenly not be reported. If a patient has been diagnosed out of state it is important to report the case in all instances. (Michigan does have an exchange agreement with some states to exchange data concerning cancer cases of Michigan residents, **but not** with all states.) These cases MUST be reported regardless of the state of diagnosis. Report all cases treated in your facility that were diagnosed outside Michigan or in an unknown facility.

- **Reporting Non-residents** Out of state residents are reportable. Non-resident cases cannot be skipped due to a presumption that only resident cases are necessary. ALL cancer cases are required to be reported regardless of residency. Report all cases regardless of the patient's address or state of residency.

- **Referrals to Another Facility** Cases can be missed if there is a lack of communication between facilities. Especially in instances where a patient was diagnosed at one facility and then referred to a second facility for treatment and each facility assumed that the other had reported the case. The end result was often that neither had reported this case. In a situation where hospitals are referring patients, it is recommended that the diagnosing facility and the hospital initially treating the patient **both** report the case. This recommendation applies to clinically diagnosed cases, in particular.

Determining Multiple Primary Tumors

For both solid tumors and hematopoietic/lymphoid neoplasms, there are specific rules to be followed when determining a new or subsequent primary. You must review the rules for each case to determine if a new primary exists.

Solid Tumor Rules

The Solid Tumor Rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions.

Refer to the 2018 Solid Tumor Rules for all cases diagnosed 1/1/2018 and later.

Note: Multiple Primary & Histology Rules for previous diagnosis years can be found in NCI SEER Historical Staging and Coding Manuals.

Hematopoietic & Lymphoid Neoplasms Manual and Database

The Hematopoietic & Lymphoid Neoplasms manual and the corresponding database are to be used for coding cases diagnosed January 1, 2010 and forward. **The changes made do not require registrars to recode old cases.**

ICD-O-3 SEER Site/Histology Validation List

Specific histologies arise in specific tissue types. Refer to the SEER site/histology validation list to determine valid primary site and histology combinations for cases diagnosed **on or after** January 1, 2001.

The Site/Histology Validation List can be downloaded by visiting the SEER website.

Most comparisons can be made to the three-digit histology code but a four-digit histology comparison is required whenever an "!" appears to the left of the three-digit histology name.

To use the SEER site/histology validation list:

1. Locate the three-digit topography code in ICD-O-3, for the primary site in question.
2. Locate the five-digit morphology code in ICD-O-3, for the primary site in question.
3. Locate the three-digit topography code in the SEER site/histology validation list in the left hand column, in numeric order by topography code.
4. Locate the five-digit morphology code in the SEER site/histology validation list in the right hand column, in numeric order by morphology code.
5. If the five-digit morphology code is listed in the right hand column, the site/histologic type is valid.
6. If the five-digit morphology code is NOT listed in the right hand column, the site/histologic type is NOT valid.

7. Confirm with your pathologist and/or managing physician if the site/histology is valid and code appropriately.

NOTE: If the primary site/histology is valid according to the pathologist and/or managing physician, document this in the text to justify the selected codes. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should NOT be generated electronically from coded values.

Diagnostic Confirmation

Descriptions of procedures performed to determine the method of diagnosis are listed below. A low number takes precedence over all higher numbers regardless of the type of procedure performed.

Positive Histology

Use code 1 for the following methods of diagnoses.

- Bone Marrow Biopsy - examination of a piece of bone marrow by puncture or trephine (removing a circular disc of bone) for possible diagnosis of leukemia or multiple myeloma
- Curettage - removal of growths or other material by scraping with a curette (D&C)
- Excisional Biopsy - the removal of a growth in its entirety and having a therapeutic as well as diagnostic purpose
- Frozen Section - a thin slice of tissue cut from a frozen specimen, often used for rapid microscopic diagnosis
- Hematologic examination - microscopic examination of the cells of the blood or blood-forming tissues (especially bone marrow) for possible diagnosis of leukemia or multiple myeloma
- Incisional Biopsy - incomplete removal of a growth for the purpose of diagnostic study
- Punch Biopsy - biopsy of material obtained from the body tissue by a punch technique
- Surface Biopsy - scraping of cells from surface epithelium, especially from the cervix, for microscopic examination
- Surgical Biopsy - removal of tissue from the body by surgical excision for examination

Endoscopic Procedures

Use code 1 (histology) if a “piece of tissue” is taken and examined under a microscope.

Use code 2 (cytology) if “fluid” is taken and examined under a microscope.

Use code 6 (visualization) if no tissue or fluid is taken and a diagnosis of cancer is made.

Examples:

A patient undergoes a bronchoscopy with a bronchial washing.
Code the method of diagnosis as: 2 - cytology

A patient undergoes a colonoscopy with a biopsy of a mass.
Code the method of diagnosis as: 1 - histology

Endoscopy Terminology

Procedure	Refers to examination of…
Bronchoscopy	Bronchi
Colonoscopy	Colon and rectum by means of an elongated flexible fiberscope
Colposcopy	Tissue of the cervix and vagina by use of a magnifying lens inserted into the vagina
Culdoscopy	Female pelvic viscera by means of an endoscope introduced through the posterior vaginal wall into that part of the pelvic cavity known as the rectovaginal pouch or cul de sac
Cystoscopy	Interior of the urinary bladder by means of a cystoscope
Esophagoscopy	Interior of the esophagus
Gastroscopy -	Interior of the stomach
Laryngoscopy	Larynx
Laparoscopy	Intra-abdominal structures by means of an illuminated tubular instrument inserted through a small incision in the abdominal wall
Mediastinoscopy	Mediastinum by means of a tubular instrument permitting direct inspection of the area between the lungs
Nasopharyngoscopy	Nasopharynx, pharynx, and the pharyngeal end of the auditory tube by lighted telescopic endoscope
Ophthalmoscopy	Interior of the eye with an instrument containing a perforated mirror and lens
Otoscopy	Internal ear
Panendoscopy	Urinary bladder via wide angle viewing
Peritoneoscopy	Peritoneal cavity by an instrument inserted through the abdominal wall
Proctoscopy	Rectum
Sigmoidoscopy	Colon up to sigmoid flexure
Thoracoscopy	Pleural cavity by means of an endoscope which is inserted into the cavity through an intercostal space

Positive Cytology

Use code 2 for the following methods of diagnoses.

- Aspiration Biopsy - biopsy of material obtained by suction through a needle attached to a syringe
- Brushings - the procedure of brushing the lining of an organ for the purpose of obtaining cells
- Fine Needle Aspiration (FNA) - a hollow needle used for withdrawing fluid from a cavity
- Paracentesis - surgical puncture of a cavity, such as the abdominal cavity, for aspiration of fluid
- Punctures - inserting a hollow needle into a cavity or organ for the purpose of removal of some portion of the contents
- Scraping - the procedure of scraping the lining of a structure with an instrument for the purpose of obtaining cells

- Swab - using a swab or similar device to obtain fluid and secretions which then can be used to make a smear
- Thoracentesis - surgical puncture for aspiration of fluid from the chest
- Washings - the removal of fluid from a hollow organ or structure for the purpose of collecting cells

Visualization

Use code 6 for the following method of diagnosis.

- Exploratory surgery - surgery is performed to determine whether or not a cancerous condition exists and the degree to which the cancer may have affected other organs and structures within the observed area; no biopsies are taken

Radiographic Examination

Use code 7 for the following methods of diagnoses.

Radiographic examination refers to a negative image on photographic film made by exposure to x-rays or gamma rays that have passed through matter or tissue.

1. Angiography - radiographic study of the vascular system
    a. Cerebral Angiogram - x-ray of the vessels of the brain
    b. Cardiac Angiogram - x-ray showing the functions of the heart and large blood vessels
    c. Lymphangiogram - x-ray study of the vessels of the lymphatic system
    d. Arteriography - x-ray examination of arteries
    e. Venography - x-ray examination of veins

2. Bronchography - radiographic study of the bronchi of the lung
    a. Bronchogram - x-ray of the bronchial system

3. Cholecystography - radiologic study of the function of the gallbladder and bile ducts after an opaque medium has been introduced either orally or intravenously
    a. Cholangiogram - x-ray of extrahepatic ducts
    b. Cholecystogram - x-ray of the gallbladder

4. Computerized (Axial) Tomography (CT) - examination of body tissue; directs a thin, concentrated beam of radiation through a cross-section of the body to detectors; the technique involves recording of “slices” of the body with an x-ray scanner

5. Hysterosalpingography - radiography of the uterus and fallopian tubes after the injection of radiopaque material

6. Infusion Nephrotomography - radiographic visualization of the kidney by tomography after intravenous introduction of contrast medium

7. Intraoperative Imaging - an imaging procedure such as x-ray, CT scan, ultrasound, or mammogram that is performed during an operative procedure, e.g., to direct a biopsy or to verify the position of a prosthesis

8. KUB (Kidneys, Ureter, Bladder) - a frontal film of the abdomen taken in the supine position

9. Laminography - x-ray of a selected layer of the body; usually performed on joints and eye orbits

10. Lower GI series or Barium Enema - x-ray studies, following rectal injection of barium, of the large bowel; air and barium are used as contrast materials

11. Mammogram - several x-ray views are taken of one or both breasts and the radiographs are examined for the presence of a lesion, mass or calcification

12. Magnetic Resonance Imaging (MRI) - based on magnetization of the various biological tissues; does not use any ionizing radiation (such as x-rays) and is capable of direct imaging in any plane without reformatting

13. Myelography - radiologic study of the spinal cord

14. Positron Emission tomography (PET) - is a unique noninvasive technique that produces three-dimensional images within inside the human body. Compounds like glucose, oxygen, and carbon, which are found naturally in body chemistry, are labeled with signal-emitting tracers and injected into the body. All cells use this tracer, and cells with increased metabolism use more glucose. Because cancer cells are highly metabolic and use more glucose than normal cells, they are easily seen on a PET scan.

15. Radioisotopes - substance administered to patients in order to diagnose disease in which the radioisotopes gather in the infected area emitting gamma rays from within the body which enable the physician to visualize internal abnormalities

16. Salpingography - radiologic study of the uterus and fallopian tubes

17. Sialography - radiologic study of the salivary ducts

18. Thermography - technique for detecting cancer by differentiating regions of hot and cold in the body; the surface temperature is photographically recorded

19. Tomography - a special x-ray technique to show in detail images of structures lying in a predetermined plane of tissue while blurring or eliminating detail in images of structures in other planes; usually performed on the kidneys

20. Upper GI series or Barium Swallow - x-ray studies, following ingestion of barium, of the pharynx, esophagus, stomach, and duodenum

21. Urography - radiologic study of the urinary tract
    a. Urogram - x-ray of the kidney and ureter with emphasis on the pelvis of the kidney by intravenous injection of a contrast medium
    b. Cystogram - x-ray of the urinary bladder by filling the bladder by catheterization with a contrast medium
    c. IVP (intravenous pyelography) - a succession of x-ray films of the urinary tract following the injection into a vein of an iodine-containing substance which is collected by the kidneys, passing into the ureters and subsequently the bladder, allowing the study of urinary tract function

d. Retrograde Urography - examination of the ureter and renal collecting structures by means of instillation of contrast material through a ureteral catheter passed through a cystoscope into the bladder and ureter

22. Ultrasound - high-frequency sound waves; waves can be bounced off of tissues using special devices. The echoes are then converted into a picture called a sonogram. Ultrasound imaging, referred to as ultrasonography, allows physicians and patients to get an inside view of soft tissues and body cavities, without using invasive techniques.

Cancer Staging

SEER Summary Stage

Responsible organization: NCI SEER

- Designed to reflect changes in the AJCC 8th Edition.
- **Must be directly assigned/coded**. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.
    - Directly assigned/coded SEER Summary Stage 2000 required for all cases diagnosed prior to 2018.
    - Directly assigned/coded SEER Summary Stage 2018 required for all cases diagnosed in 2018 and later.

Refer to the NCI SEER web site for more information.

AJCC TNM Staging

Eighth Edition
Directly assigned 8th Edition TNM Stage values are **Required** by the Michigan Cancer Surveillance Program from CoC facilities beginning with cases diagnosed January 1, 2018. Additionally, directly assigned AJCC TNM Stage, 8th edition is **Reportable** (recorded) by non-CoC facilities if staging assignment is recorded in the patient's medical record. Note that registrars for non-CoC facilities are NOT required to conduct follow-back to identify stage. However, appropriate default values must be entered. Refer to "Reporting Requirements by Data Item and Facility Type" document on MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program for complete reporting instructions.

Seventh Edition
AJCC TNM Stage, 7th Edition is a **Required** data item for CoC facilities for cases diagnosed prior to 2018. For non-CoC facilities, AJCC TNM Stage, 7th Edition is a **Reportable** data item, beginning with cases diagnosed 1/1/2016 through 12/31/2017. Refer to "Reporting Requirements by Data Item and Facility Type" document on MCSP web page: https://www.michigan.gov/mdhhs/doing-business/providers/forms/michigan-cancer-surveillance-program for complete reporting instructions.

For more information, refer to the AJCC Cancer Staging Manual. For AJCC TNM Stage training, refer to the Registrar education section on the AJCC web site.

Physicians are responsible for documenting physician-assigned clinical and pathologic stage in the patient medical record. Hospital registrars are responsible for recording the physician-assigned stage in the registry database.

Collaborative Staging (For cases diagnosed prior to 2018 only)

All CS data items required for cases diagnosed 2004 – 2015. Site Specific Factor (SSF) data items only are required for cases diagnosed 2016 – 2017.

For Schema-specific data requirements, refer to Collaborative Stage Data Collection System.

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Quality Control

Quality control measures are essential to establish accuracy, completeness and consistency of reporting within the registry. Internal quality control relates to the process that is established to check for errors and discrepancies as reports come into the registry from the reporting facilities. External quality control is a method that checks for errors and discrepancies at the reporting facility.

NOTE: Some of the edit checks are prompts to review unusual data such as a prostate gland cancer in a man less than 45 years of age. If it is something rare, please review it with your pathologist.

Internal Quality Control

Proper Completion

As the reports are received, they are reviewed for consistency and completeness. Whenever a case is incomplete or inconsistent relative to an essential data item or items the department will query the reporting facility to clarify the case. A copy of the report in question is sent to the reporting facility with a request to clarify or complete the essential data item or items. However, it is customary to make a telephone call rather send out a letter requesting clarification.

Commonplace Essential Data Deficiencies

Data Field	Deficiency
Patient's first name	If blank or inconsistent, unknown or illegible
Patient's last name	If blank or unknown or illegible
Complete address	If blank, illegible or inconsistent
Sex	If blank or inconsistent with name or site
Date of Birth	If blank or inconsistent with site, report date, or date of diagnosis
Social Security Number	If blank
Primary site	If blank or inconsistent with histology
Laterality	If blank and a paired organ is reported for the primary site
Histology	If blank, if inconsistent with the primary site or it indicates the condition may not be reportable
Stage	If inconsistent with histology, blank, or, for TNM values, not consistent with the AJCC staging system
Method of diagnosis	If blank or inconsistent as in an in-situ diagnosis not based upon a microscopic method of diagnosis
Non-diagnostic method	If method of diagnosis is reported as cytology and the case is in-situ, VIN III or CIN III, or a Pap smear, the case will be queried, to determine if a histological confirmation was obtained
Treatment	If blank and if the report is from a hospital with a cancer treatment center

If the reporting facility cannot supply the needed data items requested, the next step is to query the attending physician. For such cases, the complete name and office address of the physician are requested from the reporting facility.

For independent laboratories that do not have access to necessary patient demographic information to complete the report, adding the name and office address of the doctor to the report is extremely helpful. This reference information on the physician should be added to the **bottom** of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

Manual checks of new reports Routine checking of incoming reports identifies problems early in the processing. Letters are prepared to survey the hospital, laboratory or doctor to obtain information or clarification on identified problems. The situations that will result in a letter of inquiry include when:

- important information on the patient is missing
- the diagnosis is vague or not clearly a malignancy
- the diagnosis is an in-situ lesion based upon a cytological diagnosis
- diagnostic information is missing
- logical inconsistencies are evident, such as date of birth that is the same as the date of the report, cancer sites that disagree with the patient's sex or sites and histologies that are not compatible

If reporting a case that will likely generate a query, such as a CIN III pap smear or a patient with an unknown residence, record the physician's name and address in the lower margin of the report. This information will allow the MCSP staff to contact the doctor directly.

Computer edit checks A series of edit checks are employed to scan incoming data. Many of these checks are basic screens of the data to insure all codes are valid. Other edits are more complex. These include the standard edit checks for sex and site, site and histology, histology and stage and other edits patterned after those employed at the National Cancer Institute and as recommended by NAACCR. Problems identified by these edits may result in additional inquiries concerning a cancer report.

External Quality Control

A quality control field representative will visit each contributing facility to conduct a review of the quality of the cancer reporting at that facility. The field representative will help the facility identify and solve problems associated with casefinding, timeliness, abstracting, reporting, etc. Facility staff responsible for submitting reports are encouraged to contact their quality control field representative with questions about cancer reports.

Facility Audit Procedure

The reporting of cancer cases by Michigan licensed hospitals and laboratories are required by Act No. 82 of 1984. Administrative Rule 325.9053 provides the Michigan Cancer Surveillance Program (MCSP) with the authority to conduct quality assurance reviews within each reporting entity to ensure consistency and completeness of the statewide cancer incidence registry.

MCSP quality improvement field representatives (CTRs) are to conduct periodic facility quality review as applicable. These reporting facilities may be requested to conduct the following:

- provide access to all health records as requested for quality review in the format and timeframe as specified and/or agreed upon between the facility and the MCSP
- submit master disease index and/or pathology reports
- provide adequate work space for field representative if quality review is on site at facility
- provide access to all pertinent reports/records, which may include pathology, radiation, chemotherapy, laboratory, radiology and other treatment indices
- if quality review is conducted via remote access to the facilities electronic health record (EHR) system, all applicable paperwork and access to the facilities EHR system must be established and available during the timeframe as specified by MCSP

- be available for consultation during quality control reviews and summation

Selecting Cases for Audit

A percentage of all accepted cases are re-abstracted to assess the accuracy of abstracting and interpretation of data definitions. These cases are selected and re-abstracted without reference to the original abstract. Discrepancies between abstract and re-abstract are discussed by the original abstractor and the field representative. The re-abstracting study is a tool by which the abstractor and the MCSP staff can identify areas of inconsistency and improve the overall reliability of the registry database.

1. The diagnosis year for audit should be the last complete year the department has closed out or the last complete diagnosis year submitted by that facility. A combination of no more than two diagnosis years will be used when the minimum number of cases is not obtainable.

2. Generate a report from CRS Plus by diagnosis year(s), using class of case codes (refer to the NAACCR Data Standards Dictionary). This report will be used in Step #3 and should contain the following information.

    a. State file number
    b. Name of patient
    c. Street address
    d. City
    e. State
    f. Zip
    g. Marital status
    h. Social security number
    i. County of residence
    j. Date of birth
    k. Sex
    l. Race
    m. Hispanic origin
    n. Accession number/sequence number
    o. Class of case
    p. Primary site
    q. Laterality
    r. Histology
    s. Cell behavior
    t. Tumor grade
    u. Date of diagnosis
    v. Method of diagnosis
    w. SEER summary stage
    x. Tumor size
    y. AJCC Edition
    z. AJCC Staging (clinical and\or pathological)
    aa. Date first therapy initiated
    bb. Reason no surgery
    cc. Date of surgery
    dd. Surgery code
    ee. Date of radiation therapy
    ff. Radiation therapy code

gg. Date of chemotherapy
hh. Chemotherapy code
ii. Date of hormone therapy
jj. Hormone therapy code
kk. Date of BRM therapy
ll. BRM therapy code

3. Determine the number of cases to audit using the following methodology.

   a. If the number of reportable cases for a specific diagnosis year is 1-400, a **minimum** of forty cases must be selected for review.

   b. If the facility has thirty-six cases for the specific year being audited, it is NOT necessary to add an additional year to reach the minimum of forty cases.

   c. If the facility has less than thirty-six cases for the specific year being audited, combine two years of complete data to reach forty cases. Additional cases should be selected succeeding the current audit year. If the combination of TWO years does not meet the minimum of forty cases, do NOT add additional years.

   d. If the number of reportable cases for a specific diagnosis year is 401-799, select ten percent (10%) of the cases for review.

   e. If the number of cases for a specific diagnosis year is greater than 800, a **maximum of eighty** cases will be selected for review.

4. For facilities with less than 400 cases, a minimum of forty cases from a select group of primary anatomical sites will be audited at each facility. If the minimum number of cases selected for each assigned primary anatomical site is NOT reached, select additional cases from the facilities top five reported sites or other sites such as esophagus, larynx, pancreas, testis, pharynx, etc. Discretion should be used when selecting additional primary anatomical sites to include a diverse number of sites. Audits are determined annually based on review of registry data.

5. For facilities with over 401 cases, select ten percent (10%) up to a maximum of eighty cases. Select the cases for each assigned primary anatomical site as outlined above for the minimum forty cases. Use discretion when selecting additional primary anatomical sites to include a diverse number of sites. If there is not a variety of primary sites, review the baseline of forty cases above and choose additional cases up to the ten percent (10%) or a maximum of eighty.

6. Those facilities that have not submitted cases for the specified audit year, a review of their MDI must take place and there will be no records to audit. The results of the MDI will determine if the facility should have reported cases. This will also determine how far back the department should abstract any backlog.

7. For those facilities that do not report their own cases, a review of their MDI must take place and there will be no records to audit. The records at the reporting facility will be reviewed for accuracy.

Master Disease Index Review

1. A Master Disease Index (MDI) from the facility for the same diagnosis year as the audit year will be Requested. The ICD-9-CM/ICD-10-CM codes identified in Sources for Casefinding are used by the facility to generate the master disease index.

2. Patients seen at the facility as an inpatient and/or as an outpatient must be selected. If possible, the facility will eliminate any duplicates that may appear in the listing. If a patient is seen with active or previously diagnosed cancer and is admitted for an unrelated medical condition, exclude these patients from the main listing.

3. The MDI will be submitted the MCSP in an Excel file with the following information:

    a. patients full name (alphabetical order by last name)
    b. date of birth
    c. social security number
    d. ICD-9-CM/ICD-10-CM diagnostic code
    e. admit date
    f. discharge date

4. Upon receipt of the file, it will be electronically compared to the cancer registry for complete casefinding.

5. A list identifying the cases that did NOT appear in the registry will be generated. This list will be sent back to the facility for verification of non-reportable conditions.

Pathology Review
In addition to the MDI comparison, a total of 120 pathology reports for the specific diagnosis year being audited is required for additional case ascertainment. The pathology reports must be separated into reportable and non-reportable conditions, with the reportable conditions compared to the central cancer registry.

Data Items Reviewed During the Audit		
Name of Patient	Medical Record Number	SEER Summary Stage
Street Address, City, Zip	Primary Site	Tumor Size
County	Paired Organ	AJCC – TNM Values
Social Security Number	Clinical/Histological Diagnosis	AJCC – Stage Group
Date of Birth	Cell Behavior	Date Therapy Began
Sex	Tumor Grade	Reason No Surgery
Race	Date of Diagnosis	Surgery Dates and Codes
Hispanic Origin	Method of Diagnosis	First Course of Treatment

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Recommended Abbreviations for Abstractors

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

Never abbreviate the names of facilities; spell them out fully:

- Correct: University of Michigan
- Incorrect: UoM

For a list of recommended abbreviations for abstractors, refer to NAACCR Data Standards & Data Dictionary, Appendix G

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Reference Links for Registrars, Abstractors and Other Cancer Reporters

U.S. State, Territory, Commonwealth, U.S. Possession, and Canadian Province or Territory Codes

Two-character State or Province/Territory codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix B1: SEER Program Coding and Staging Manual 2021

Alphabetic Listing of Country Codes (ISO-3 Alpha Codes)

Three-character ISO Country codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix B1: SEER Program Coding and Staging Manual 2021

FIPS Codes for Counties and Equivalent Entities

Three digit FIPS codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix A: NAACCR Data Standards & Data Dictionary

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Manuals and Reporting Guides

Michigan Cancer Surveillance Program

MCSP Cancer Reporting Manual

AJCC

AJCC Cancer Staging
AJCC 8th Edition will be used beginning with cases diagnosed 1/1/2018. Refer to the AJCC web site for more information on the AJCC Staging System, how to purchase the AJCC Cancer Staging Manual 8th edition, a review of staging rules, and errata to the 8th edition, AJCC news, education and training.

Collaborative Stage Data Collection System
Schema and site specific factors for cases diagnosed prior to 2018

NCI SEER

Solid Tumor Rules (for cases diagnosed in 2018 and later)
Multiple Primary and Histology Coding Rules (for cases diagnosed prior to 2018)

SEER Program Coding and Staging Manual 2021 (for cases diagnosed in 2021 and forward)

SEER Summary Stage 2018 (for cases diagnosed in 2018 through the end of 2020)
SEER Summary Staging Manual 2000 (for cases diagnosed prior to 2018)

SEER EOD 2018 (for cases diagnosed in 2018 and later)
All CoC facilities are required to submit EOD data. Further, all facilities (regardless of type) that submit data to the Metropolitan Detroit Cancer Surveillance System (also known as Karmanos Cancer Institute) are required to submit EOD data. All other facilities are encouraged to report EOD data when collected.

Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual

SEER*Rx - Interactive Antineoplastic Drugs Database

ICD-O-3 SEER Primary Site/Histology Validation List

Commission on Cancer (CoC)

STORE Manual
Use this manual for current cases. In most instances, it also should be used for historic cases being abstracted currently; exceptions are noted in the text.

NAACCR

NAACCR Site Specific Data Items (SSDI) / Grade
The NAACCR Site Specific Data (SSDI) / Grade page includes schema specific codes and coding instructions, a .pdf of the SSDI Manual, and a .pdf of the Grade Manual.

Data Standards & Data Dictionary, Volume II
The Data Standards and Data Dictionary provides detailed specifications and codes for each data item in the NAACCR data exchange record layout.

ICD-O-3 Histology Coding

International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3) – This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization.

ICD O 3 Coding Updates- 2022 ICD O 3 Coding Guidelines updated: 7/29/2021

ICD-O-3 errata and clarifications

For 2021, standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the World Health Organization Classification of Tumors. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021. The new codes, new terms, and codes with changes to behavior are available at the NAACCR website.

Registrar Education and Training

AJCC Registrar Education

CAnswer Forum
An interactive bulletin board to ask questions, search topics, and connect with activities. It is designed as an open forum for networking and discussion.

Michigan Cancer Registrars Association (MICRA) Educational Resources

NAACCR Annual Conference and Training
Find events, webinars and educational resources offered by NAACCR and its partners.

National Cancer Registrars Association (NCRA)
The Center for Cancer Registry Education is designed to provide easy access to high-quality educational programming to support both seasoned professionals and those new to the field.

SEER*Educate
This comprehensive training platform is tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts.

SEER Training
SEER's Training Website was developed to provide web-based training modules for cancer registration and surveillance.

Cancer Organizations

American Cancer Society

American College of Surgeons (ACoS)

American Joint Commission on Cancer (AJCC)

Cancer Registrar's Guide to Collecting Industry and Occupation

Centers for Disease Control and Prevention (CDC)

College of American Pathologists (CAP)

Commission on Cancer (CoC)

International Classification of Diseases (ICD-9, ICD-10)

International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)

Michigan Cancer Registrar's Association (MICRA)

National Cancer Institute (NCI)

National Cancer Registrars Association (NCRA)

National Program of Cancer Registries (NPCR)

North American Association of Central Cancer Registries (NAACCR)

Surveillance, Epidemiology, and End Results Program (SEER)

World Health Organization (WHO)

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